-ORIGINAL-

WEST TENNESSEE REHABILITATION CENTER

CN1510-044

Received 10/14/15
11:00 a.m.

1. ***Name of Facility, Agency, or Institution***

West Tennessee Rehabilitation Center
Name

616 West Forest Avenue — Madison
Street or Route — County

Jackson — TN — 38301
City — State — Zip Code

2. ***Contact Person Available for Responses to Questions***

Victoria S. Lake — Director
Name — Title

Jackson-Madison County General Hospital — Vicki.lake@wth.org
Company Name — Email address

620 Skyline Drive — Jackson — ____ — ____
Street or Route — City — State — Zip Code

employee — (731) 984-2160 — (731) 984-2197
Association with Owner — Phone Number — Fax Number

3. ***Owner of the Facility, Agency or Institution***

West Tennessee Rehabilitation Hospital LLC — (205)970-7926
Name — Phone Number

1209 Orange Street — New Castle
Street or Route — County

Wilmington — Delaware — 19801
City — State — Zip Code

4. ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship	____	F. Government (State of TN or Political Subdivision)	____
B. Partnership	____	G. Joint Venture	____
C. Limited Partnership	____	H. Limited Liability Company	X
D. Corporation (For Profit)	____	I. Other (Specify)_____	____
E. Corporation (Not-for-Profit)	____		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity*** ***(If Applicable)***

HealthSouth Corporation
Name

3660 Grandview Parkway Suite 200 — Jefferson
Street or Route — County

Birmingham — AL — 35243
City — State — Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution*** ***(Check One)***

A. Ownership		D. Option to Lease	
B. Option to Purchase		E. Other (Specify) _____	
C. Lease of 35 Years	X		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution*** ***(Check as appropriate--more than one response may apply)***

A. Hospital (Specify) rehabilitation	X	H. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty		I. Outpatient Diagnostic Center	
		J. Rehabilitation Facility	
C. ASTC, Single Specialty		K. Residential Hospice	
D. Home Health Agency		L. Nonresidential Substitution-Based Treatment Center for Opiate Addiction	
E. Hospice			
F. Mental Health Hospital			
G. Intellectual Disability Institutional Habilitation Facility (IDIHF) (ICF/IID formerly (ICF/MR)		M. Birthing Center	
		N. Other Outpatient Facility	
		O. Other (Specify) _____	

8. ***Purpose of Review*** ***(Check as appropriate--more than one response may apply)***

A. New Institution	X	G. Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
B. Replacement/Existing Facility			
C. Modification/Existing Facility			
D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)_____		H. Change of Location	
		I. Other (Specify) _____	
E. Discontinuance of OB Services			
F. Acquisition of Equipment			

9. ***Bed Complement Data***

Please indicate current and proposed distribution and certification of facility beds.

	Current Beds Licensed	Current Beds *CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A. Medical					
B. Surgical					
C. Long-Term Care Hospital					
D. Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolescent Psychiatric					
K. Rehabilitation				48	48
L. Nursing Facility - SNF (Medicare only)					
M. Nursing Facility – NF (Medicaid only)					
N. Nursing Facility – SNF/NF (dually certified Medicaid/Medicare)					
O. Nursing Facility – Licensed (non-Certified)					
P. IDIHF					
Q. Adult Chemical Dependency					
R. Child and Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL				48	48

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** apply for new number

Certification Type _____

11. **Medicaid Provider Number** apply for new number

Certification Type _____

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?**

X Yes

_____ No

_____ NA

13. **Will this project involve the treatment of TennCare participants?** yes

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response:

Proposed Services and Equipment

This project proposes, in effect, to relocate the West Tennessee Rehabilitation Center, a 48-bed hospital-based unit located within Jackson-Madison County General Hospital that provides inpatient rehabilitation services to residents of the Jackson-Madison County General Hospital service area, to a freestanding 59,450 square foot state-of-the-art dedicated inpatient rehabilitation facility at 616 West Forest Avenue, Jackson, Tennessee, a site adjacent to the Jackson-Madison County General Hospital campus. The proposed facility will provide a broad range of comprehensive inpatient rehabilitation services. The project contains no major medical equipment. If this application is approved, Jackson-Madison General Hospital will de-license the 48 beds when the facility proposed in this application is licensed. A letter to this effect is provided in the attachments to this application.

Ownership Structure

The applicant for this project is a newly created entity, West Tennessee Rehabilitation Hospital LLC. The ownership of this entity is as follows: the Jackson-Madison County General Hospital District, 50 percent; and HealthSouth Corporation 50 percent. The proposed joint venture will also include the ownership of HealthSouth Cane Creek Rehabilitation Center, an existing 40-bed facility in Martin, Weakley County, Tennessee.

The West Tennessee Rehabilitation Center is a 48-bed unit currently owned and operated as part of the Jackson-Madison County General Hospital District. Upon completion of this project, the new facility will be known as West Tennessee Rehabilitation Center, a joint venture between Jackson-Madison County General Hospital District d/b/a West Tennessee Healthcare and HealthSouth Corporation, the nation's largest operator of comprehensive inpatient rehabilitation services. HealthSouth currently operates seven comprehensive inpatient rehabilitation facilities within the state of Tennessee, with an eighth scheduled to open in December 2015.

Jackson-Madison County General Hospital is the flagship facility of West Tennessee Healthcare with 635 licensed and operating beds, including 233 medical/surgical beds, 15 pediatric beds, 42 obstetric beds, 34 neonatal intensive care beds, 75 intensive care beds, 188 intermediate care beds, and the 48 inpatient rehabilitation beds known as the West Tennessee Rehabilitation Center. West Tennessee Healthcare also operates three other acute care hospitals: Bolivar General Hospital; Camden General Hospital; and Milan General Hospital. Bolivar General Hospital is licensed for 51 acute care beds and is located approximately 30

miles southwest of Jackson-Madison County General Hospital in Bolivar, Tennessee. Camden General Hospital is a 25-bed Critical Access Hospital approximately 65 miles northeast of Jackson-Madison County General Hospital in Camden, Tennessee. Milan General Hospital is licensed for 70 acute care beds and is located in Milan, Tennessee, approximately 25 miles north of Jackson-Madison County General Hospital.

West Tennessee Healthcare is the business name of The Jackson-Madison County General Hospital District, which was created in 1949 by the city of Jackson, Tennessee, and Madison County, Tennessee. Through Jackson-Madison County General Hospital and other affiliates, West Tennessee Healthcare provides service in seventeen (17) counties in west Tennessee. West Tennessee Healthcare also receives patients through its membership in the Vanderbilt Health Affiliated Network (VHAN), a clinically integrated network that as of January 2015 included over 100,000 covered lives and over 3,200 providers. West Tennessee Healthcare also entered into an affiliation agreement with Vanderbilt University Medical Center in 2013.

Please see the attached information labeled **Section A – Applicant Profile – 4** for charts showing the ownership structure of Jackson-Madison County General Hospital and for the Tennessee facilities owned by HealthSouth Corporation.

Service Area

The service area for the proposed facility is the same as the service area for Jackson-Madison, which is seventeen (17) counties in west Tennessee, including Madison, Gibson, Chester, Crockett, Henderson, Hardeman, Haywood, and Carroll Counties in its primary service area, while the secondary service area contains Obion, McNairy, Dyer, Hardin, Weakley, Decatur, Benton, Lauderdale, and Henry Counties. For 2014, the counties in the primary service area accounted for 18,777 of the hospital's 26,732 discharges, or 70.2 percent. According to population projections published by the Tennessee Department of Health, the estimated 2015 population for the service area for Jackson-Madison is 533,505 persons. For 2019, the expected population is 538,691 persons.

Need

The project seeks no additional comprehensive inpatient rehabilitation beds, but merely seeks, in effect, to relocate existing beds. The project will improve the delivery of healthcare services by construction of a new state-of-the-art freestanding facility with forty-eight (48) private rooms adjacent to the current location. The existing beds are highly utilized.

The project also addresses the need for private rooms. The current standard of hospital design at the American Institute of Architects, which has been adopted by Tennessee's Board for Licensing Healthcare Facilities, is all private rooms. Private rooms improve the care environment, reduce the incidence of nosocomial infections, and allow providers to operate at higher overall bed occupancies.

Please see the response to **Section C – Need – 1** for additional information.

Existing Resources

Within the seventeen (17) west Tennessee Counties that comprise the West Tennessee Healthcare service area, there are sixteen (16) acute care hospitals. The only other provider of comprehensive inpatient rehabilitation services in the service area is the 40-bed HealthSouth Cane Creek Rehabilitation Center, which is located in Weakley County approximately 55 miles from West Tennessee Rehabilitation Center.

Project Cost, Funding, Financial Feasibility, and Staffing

The estimated cost of the project is $34,329,180. The joint venture partners, West Tennessee Healthcare and HealthSouth Corporation, will provide funding through current cash reserves. For Year Two past project completion, it is anticipated that 41 FTEs will be needed.

B.II Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

> **A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. 68-11-1601 et seq.) including square footage, major operational areas, room configurations, etc. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. $ 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E.**

Response: The following describes the proposed construction:

Design of the Facility

West Tennessee Rehabilitation Center is currently housed in a forty-eight (48) bed distinct part unit of Jackson-Madison County General Hospital. The project seeks approval to construct a new, state-of-the-art freestanding rehabilitation hospital at 616 West Forest Avenue, a site adjacent to the current campus. The project addresses the need for private rooms at the facility and also benefits patient care by providing a facility dedicated solely to the provision of comprehensive inpatient rehabilitation services. Private rooms benefit patients and allow providers to operate at higher overall occupancy percentages. The latter provides economies of scale and lowers overall healthcare costs per patient served. The proposed construction and renovation will meet the current standards for hospital design promulgated by the American Institute of Architects. The Tennessee Board of Licensing Healthcare Facilities has adopted these standards.

The proposed building is a one-story facility with 59,450 gross square feet that will contain forty-eight (48) new private patient rooms and shell space for future expansion, if necessary. The canopied entrance and lobby are on the building's North Side. The Eastern part of the building contains the therapy gymnasium, the dining area, the kitchen, and the administrative offices. A nursing station will occupy the intersection of the two corridors containing patient rooms. Drawings of the site and the proposed project are provided in the responses to **Section B – Project Description – III(A)** and **Section B – Project Description – IV**.

Please also discuss and justify the cost per square foot for this project.

The project's $214.14 cost per SF cost for new construction is based on research conducted by HealthSouth's architect into recent and local construction costs. This is slightly lower than

the median costs for hospital construction projects approved by the HSDA for the years 2012-2014. This information is presented in the following table.

	2012-2014 Median	West Tennessee Rehabilitation Center
New Construction	$259.66/SF	$214.14/SF

If the project involves none of the above, describe the development of the proposal.

Response: Not applicable (NA)

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost / SF		
					Renovated	New	Total	Renovated	New	Total
Main Entry & Lobby						1,382.4	1,382.4		$225/sf	$ 311,040
Administration						3,434.4	3,434.4		$200/sf	$ 686,880
Dietary						2,493.0	2,493.0		$240/sf	$ 598,320
Environmental/Supply Chain						1,054.8	1,054.8		$118/sf	$ 124,466
Plant Services						1,903.2	1,903.2		$180/sf	$ 342,576
Nursing Unit (48 Bed)						18,145.2	18,145.2		$250/sf	$ 4,536,300
Shell Space (10 Bed)						6,120	6,120		$150/sf	$ 918,000
Physician Office						1,084.8	1,084.8		$200/sf	$ 216,960
Dining						1,728.0	1,728.0		$200/sf	$ 345,600
Recreation/Day Room						1,484. 4	1,484. 4		$200/sf	$ 296,880
Activities for Daily Living						508.8	508.8		$200/sf	$ 101,760
Pharmacy						597.6	597.6		$200/sf	$ 119,520
Physical Therapy						6,956.4	6,956.4		$220/sf	$ 1,530,408
Psych/OT/Speech						561.6	561.6		$200/sf	$ 112,320
Social Services/Case Management						800.4	800.4		$200/sf	$ 160,080
Unit/Depart. GSF Sub-Total						**48,255**	**48,255**			**$10,401,110**
Mechanical/ Electrical GSF						**578**	**578**		**$300/sf**	**$ 173,400**
Circulation /Structure GSF						**10,617**	**10,617**		**$203.08/sf**	**$ 2,156,113**
Total GSF						59,450	59,450		$214.14	$12,730,623

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response: There will be no change in the number of inpatient rehabilitation beds as a result of this project. Upon approval of this certificate of need and completion of the project, the forty-eight (48) beds currently housed in Jackson-Madison County General Hospital will be delicensed. A letter from the President and CEO of West Tennessee Healthcare, Mr. Bobby Arnold to this effect is attached to this application in **Attachment B.II.B.**

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. **Adult Psychiatric Services**
2. **Alcohol and Drug Treatment for Adolescents (exceeding 28 days)**
3. **Birthing Center**
4. **Burn Units**
5. **Cardiac Catheterization Services**
6. **Child and Adolescent Psychiatric Services**
7. **Extracorporeal Lithotripsy**
8. **Home Health Services**
9. **Hospice Services**
10. **Residential Hospice**
11. **ICF/MR Services**
12. **Long-term Care Services**
13. **Magnetic Resonance Imaging (MRI)**
14. **Mental Health Residential Treatment**
15. **Neonatal Intensive Care Unit**
16. **Non-Residential Methadone Treatment Centers**
17. **Open Heart Surgery**
18. **Positron Emission Tomography**
19. **Radiation Therapy/Linear Accelerator**
20. **Rehabilitation Services**
21. **Swing Beds**

Response: Not applicable (NA). The applicant, owner, Jackson-Madison County General Hosptial, is an existing provider of comprehensive inpatient rehabilitation services. Its previous history of providing this service confirms the demand for the service.

D. Describe the need to change location or replace an existing facility.

Response: This project seeks approval to construct and effectively replace the existing hospital-based unit with a new forty-eight (48) private patient room hospital dedicated to inpatient rehabilitation. The existing inpatient rehabilitation unit at Jackson-Madison County General Hospital is located in one area that was constructed in the late 1950s and the other area in 1966-1968. The bathrooms are very small and have no showers so patients must use communal showers which limit the types of patients who can be admitted to the Unit. Wheelchair and walker access to the bathrooms is not available due to space. Therapy space is also very limited, and the unit lacks a dining and recreational area.

The new facility will improve the delivery of healthcare services to patients by creating a better treatment environment for patient care, one dedicated fully to the provision of inpatient rehabilitation services. Improvement in the efficiency of care delivery is expected. The proposed facility will contain all private rooms, which has been shown to reduce the incidence of nosocomial infections. The current Jackson-Madison County General Hospital inpatient rehabilitation unit contains thirty-eight (38) private rooms and five (5) semi-private rooms.

The proposed facility will contain shell space for future expansion, if warranted. Completion of the proposed project will also permit Jackson-Madison County General Hospital to devote the existing space to other needed purposes.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute), which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. **For fixed-site major medical equipment (not replacing existing equipment):**
    a. **Describe the new equipment, including:**
        1. **Total cost ;(As defined by Agency Rule).**
        2. **Expected useful life;**
        3. **List of clinical applications to be provided; and**
        4. **Documentation of FDA approval.**
    b. **Provide current and proposed schedules of operations.**
2. **For mobile major medical equipment:**
    a. **List all sites that will be served;**
    b. **Provide current and/or proposed schedule of operations;**
    c. **Provide the lease or contract cost.**
    d. **Provide the fair market value of the equipment; and**
    e. **List the owner for the equipment.**
3. **Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.**

Response: Not applicable (NA)

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:

1. **Size of site (in acres);**
2. **Location of structure on the site; and**
3. **Location of the proposed construction.**
4. **Names of streets, roads or highway that cross or border the site.**

Response: Please see the attachment labeled **Section B – Project Description III(A)** for a drawing of the proposed site of West Tennessee Rehabilitation Center.

III (B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: The proposed site for West Tennessee Rehabilitation Center is easily accessible from all surrounding areas. West Forest Avenue is an east-west route through Jackson that provides easy access to US Highway 70 to the west, US Highway 70/Highway 20 to the northeast, and US Highway 45 to the north/south. The proposed site is near Interstate 40 that bisects Jackson and provides easy access to locations east and west of the proposed site. Jackson is approximately 130 miles, or two hours drive time, from Nashville, and approximately 88 miles, or one and a half hours drive time, from Memphis. Public transportation in the City of Jackson is available through the Jackson Transit Authority and includes a bus route that travels directly past the proposed location.

IV. Attach a floor plan drawing for the facility that includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper. NOTE: DO NOT SUBMIT BLUEPRINTS. Simple line drawings should be submitted and need not be drawn to scale.

Response: Please see the attachment labeled **Section B – Project Description – IV** for drawings of the proposed floor plan for the proposed new facility.

V. For a Home Health Agency or Hospice, identify:

1. **Existing service area by County;**
2. **Proposed service area by County:**
3. **A parent or primary service provider:**
4. **Existing branches; and,**
5. **Proposed branches.**

Response: Not applicable (NA)

Section C: General Criteria for Certificate of Need

Need

1. ***Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.***

a. **Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Please list each principle and follow it with a response.**

RESPONSE:

Healthy Lives: The West Tennessee Rehabilitation Center will improve the health of Tennesseans in the 17-county service area. Overall, the Center will address the health of patients in a holistic fashion to address their personal and health issues. The new facility will be a state-of-the-art freestanding rehabilitation hospital and benefits patient care by providing a facility dedicated solely to the provision of comprehensive inpatient rehabilitation services

Access to Care: The proposed project will provide access to care for all patients, regardless of their ability to pay. Access to care will be improved by offering comprehensive inpatient rehabilitation services in one location.

Economic Efficiencies: The proposed project addresses economic efficiencies by providing a broad range of services for rehabilitation patients in one location. Services provided in one location include recreational, speech, occupational, and physical therapies. The facility will have space for activities of daily living (ADL) training kitchen, living room, dining/recreation, bedroom, as well as private treatment space.

Quality of Care: The West Tennessee Rehabilitation Center will provide quality comprehensive inpatient rehabilitation care. The facility will be monitored by The Joint Commission on Accreditation of Healthcare Organizations, and will be licensed and surveyed by the State of Tennessee Department of Health Care Facilities.

Health Care Workforce: The applicant will have sufficient and qualified workforce to staff the West Tennessee Rehabilitation Center.

b. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

Project-Specific Review Criteria: Comprehensive Inpatient Rehabilitation Services

1. **The need for comprehensive inpatient rehabilitation services shall be determined by applying the guideline of ten beds per 100,000 population to the service area of the proposal.**

Response: The seventeen (17) counties comprising the service area for Jackson-Madison County General Hospital are the service area for West Tennessee Rehabilitation Center. The 2015 population estimate for these counties indicates a need for 53 (53.3) comprehensive inpatient rehabilitation beds. In addition to the 48 inpatient

rehabilitation beds at Jackson-Madison, there are 40 inpatient rehabilitation beds at HealthSouth Cane Creek in Weakley County. Both of these facilities are well utilized.

2. The need shall be based upon the current year's population and projected four years forward.

Response: The seventeen (17) counties comprising the service area contain 533,505 residents according to the 2015 estimates published by the Tennessee Department of Health. The service area is expected to have a population of 538,691 residents by 2019, indicating a need for 54 (53.8) comprehensive inpatient rehabilitation beds. The following table contains population estimates for the West Tennessee Healthcare service area.

YEAR	2015	2019
Benton	16,208	16,071
Carroll	28,012	27,781
Chester	17,593	18,151
Crockett	14,611	14,715
Decatur	11,883	12,156
Dyer	38,246	38,482
Gibson	51,412	52,350
Hardeman	26,231	26,035
Hardin	26,075	26,310
Haywood	18,044	18,032
Henderson	28,279	28,743
Henry	32,766	33,015
Lauderdale	27,264	27,135
Madison	99,971	101,279
McNairy	26,755	27,509
Obion	31,365	31,218
Weakley	38,790	39,709
Total	533,505	538,691

3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.

Response: The appropriate geographic service area for the proposed project is the existing service area. In FY2015, West Tennessee Rehabilitation Center served patients from twenty-seven (27) Tennessee counties, with seventeen (17) of those counties providing ten (10) or more patients. The West Tennessee Rehabilitation Center also serves a small number of out of state patients. It served sixteen (16) patients from Weakley County, the host county of HealthSouth Cane Creek. The following table provides patient origin information by county for West Tennessee Rehabilitation Center for FY2015.

COUNTY	PATIENTS	DAYS
Madison	371	4,916
Gibson	133	1,586
Hardeman	58	852
Carroll	52	646
Henderson	47	661
Crockett	44	593
Chester	43	454

Dyer	42	514
McNairy	41	507
Haywood	39	562
Hardin	31	399
Decatur	24	346
Lauderdale	19	239
Obion	16	199
Weakley	16	265
Benton	15	262
Henry	12	158
Lake	7	61
Shelby	4	52
Fayette	2	18
Montgomery	2	16
Tipton	2	33
Wayne	2	19
Coffee	1	13
Perry	1	14
Williamson	1	22
Cheatham	1	8
Out of State	6	119
Total	1,032	13,534

4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.

Response: Not applicable (NA). The proposed project is for a freestanding comprehensive inpatient rehabilitation facility.

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.

Response: West Tennessee Rehabilitation Center is an existing forty-eight (48) bed distinct part unit within Jackson-Madison County General Hospital. The proposed new facility does not comply with this guideline. This project seeks, in effect, to relocate the beds to a new state-of-the-art freestanding facility that is designed for expansion, if necessary, to a site adjacent to the Jackson-Madison County General Hospital hospital campus. At this time, the applicant does not seek additional beds, but the new facility will permit this if the demand for comprehensive inpatient rehabilitation increases.

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:

20-30 bed unit — 75%
31-50 bed unit/facility — 80%
51+ bed unit/facility — 85%

Response: The project will not add any new inpatient rehabilitation beds to the market, because Jackson-Madison County General Hospital will close its unit when this facility is opened. West Tennessee Rehabilitation Center operated at 77 percent occupancy for FY2015 and has demonstrated increasing occupancy levels since FY2012. The demand for comprehensive inpatient rehabilitation services is expected to increase as

the population ages. While the current facility does not comply with this guideline currently, occupancy at the current location is expected to exceed the 80 percent level by the time the new facility's expected opening in 2017.

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board-certified physiatrist.

Response: West Tennessee Rehabilitation Center already has in place an outstanding professional staff that delivers comprehensive inpatient rehabilitation services to its patients. Staffing requirements and resources for the project are presented in the response to C(15) below. The medical director is Board Certified as a Physical Medicine and Rehabilitation Physician.

b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

Applications for a Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, the Commission may consider, in addition to the foregoing factors, the following factors:

Even though this property does not technically involve a change in site, it is a change in site practically speaking, so the change of site criteria are addressed below.

Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change the proposed new site.

Response: Approval of the proposed project will improve the delivery of health care to residents of the service by providing a dedicated facility specializing solely in the delivery of quality care to those in need of rehabilitation. The practical effect is that a dedicated facility will permit the development of additional expertise in the delivery of care and lead to better outcomes. Private rooms also reduce the risk of nosocomial infection and are more convenient for families visiting their loved ones.

Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.

Response: The economic benefit to residents will be the improved efficiency in the delivery of comprehensive inpatient rehabilitation services.

Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.

Response: There are no potential delays. High quality comprehensive inpatient rehabilitation services will continue to be delivered at the current location inside Jackson-Madison County General Hospital until the new facility is ready for occupancy.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

Response: The project is consistent with the long-range plans of West Tennessee Healthcare, Jackson-Madison County General Hospital, and HealthSouth Corporation. The project will benefit the residents of its service area and also promote efficiencies in the delivery of patient care through providing additional private rooms for patient care, enhancing both the delivery of inpatient rehabilitation services and patient convenience.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).

Response: The service area for the proposed facility is the same as the service area for Jackson-Madison, which is seventeen (17) counties in west Tennessee, including Madison, Gibson, Chester, Crockett, Henderson, Hardeman, Haywood, and Carroll Counties in its primary service area, while the secondary service area contains Obion, McNairy, Dyer, Hardin, Weakley, Decatur, Benton, Lauderdale, and Henry Counties. For 2014, the counties in the primary service area accounted for 18,777 of the hospital's 26,732 discharges, or 70.2 percent. Discharges from the secondary service area represent 22.5 percent of the total. According to population projections published by the Tennessee Department of Health, the estimated 2015 population for the service area for Jackson-Madison is 533,505 persons. For 2019, the expected population is 538,691 persons.

Please see the attachment labeled **Section C – Need – 3** for a map of the State of Tennessee showing the seventeen (17) Tennessee counties that constitute the service area for West Tennessee Rehabilitation Center.

4. A. 1). Describe the demographics of the population to be served by this proposal.

Response: The new facility will serve the same patient population as currently served. For FY2015, seventeen (17) counties in west Tennessee provided twelve or more patients to West Tennessee Rehabilitation Center and accounted for 97.2 percent (1,003 of 1,032) of the total discharges. A list of these counties, including the number of patients and patient days of care, was provided in the response to Question 3 of the Project Specific Review Criteria.

2.) Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area:

Demographic Variable/Geographic Area	Benton County	Carroll County	Service Area Total-17 counties	State of TN Total
Total Population-Current Year-2015	16,208	28,012	533,505	6,649,438
Total Population-Projected Year-2019	16,071	27,781	538,691	6,894,997
Total Population-% change	-.84%	-.82%	1.0%	3.7%
*Target Population-Current Year-2015	3,763	5,628	93,016	1,012,937
*Target Population-Projected Year-2019	3,898	5,828	99,462	1,134,565
Target Population-% change	3.6%	3.6%	6.9%	12.0%
Target Population-Projected Year as % of Total	24.3%	20.9%	18.4%	16.5%
Median Age	46.1	42.3		38.6
Median Household Income	$33,033	$35,049		$44,298
TennCare Enrollees (Aug 15)	4,098	7,764	137,810	1,447,657
TennCare Enrollees as % of Total	25.3%	27.7%	25.8%	21.8%
Persons Below Poverty Level	3,579	5,534	103,505	1,101,732
Persons Below Poverty Level as % of Total	22.1%	19.8%	19.4%	16.6%

**Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. For projects not having a specific target population use the Age 65+ population for the target population variable.*

Demographic Variable/Geographic Area	Chester County	Crockett County	Service Area Total-17 counties	State of TN Total
Total Population-Current Year-2015	17,593	14,611	533,505	6,649,438
Total Population-Projected Year-2019	18,151	14,715	538,691	6,894,997
Total Population-% change	3.2%	.71%	1.0%	3.7%
*Target Population-Current Year-2015	2,824	2,566	93,016	1,012,937
*Target Population-Projected Year-2019	2,951	2,673	99,462	1,134,565
Target Population-% change	4.5%	4.2%	6.9%	12.0%
Target Population-Projected Year as % of Total	16.3%	18.2%	18.4%	16.5%
Median Age	36.9	40.4		38.6
Median Household Income	$41,875	$36,066		$44,298
TennCare Enrollees (Aug 15)	3,944	3,986	137,810	1,447,657
TennCare Enrollees as % of Total	22.4%	27.3%	25.8%	21.8%
Persons Below Poverty Level	3,185	2,697	103,505	1,101,732
Persons Below Poverty Level as % of Total	18.1%	18.5%	19.4%	16.6%

**Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. For projects not having a specific target population use the Age 65+ population for the target population variable.*

Demographic Variable/Geographic Area	Decatur County	Dyer County.	Service Area Total-17 Counties	State of TN Total
Total Population-Current Year-2015	11,883	38,246	533,505	6,649,438
Total Population-Projected Year-2019	12,156	38,482	538,691	6,894,997
Total Population-% change	2.3%	.62%	1.0%	3.7%
*Target Population-Current Year-2015	2,583	6,424	93,016	1,012,937
*Target Population-Projected Year-2019	2,657	6,925	99,462	1,134,565
Target Population-% change	2.9%	7.8%	6.9%	12.0%
Target Population-Projected Year as % of Total	21.9%	18.0%	18.4%	16.5%
Median Age	44.8	40.2		38.6
Median Household Income	$36,258	$38,953		$44,298
TennCare Enrollees (Aug 15)	2,879	10,711	137,810	1,447,657
TennCare Enrollees as % of Total	24.2%	28.0%	25.8%	21.8%
Persons Below Poverty Level	2,589	6,718	103,505	1,101,732
Persons Below Poverty Level as % of Total	21.8%	17.6%	19.4%	16.6%

**Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. For projects not having a specific target population use the Age 65+ population for the target population variable.*

Demographic Variable/Geographic Area	Gibson County	Hardeman County	Service Area Total-17 Counties	State of TN Total
Total Population-Current Year-2015	51,412	26,231	533,505	6,649,438
Total Population-Projected Year-2019	52,350	26,035	538,691	6,894,997
Total Population-% change	1.8%	-.75%	1.0%	3.7%
*Target Population-Current Year-2015	8,875	4,308	93,016	1,012,937
*Target Population-Projected Year-2019	9,353	4,635	99,462	1,134,565
Target Population-% change	5.4%	7.5%	6.9%	12.0%
Target Population-Projected Year as % of Total	17.9%	17.8%	18.4%	16.5%
Median Age	39.9	39.7		38.6
Median Household Income	$38,343	$30,973		$44,298
TennCare Enrollees (Aug 15)	13,238	7,107	137,810	1,447,657
TennCare Enrollees as % of Total	25.7%	27.1%	25.8%	21.8%
Persons Below Poverty Level	9,097	5,771	103,505	1,101,732
Persons Below Poverty Level as % of Total	17.7%	22.0%	19.4%	16.6%

**Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. For projects not having a specific target population use the Age 65+ population for the target population variable.*

Demographic Variable/Geographic Area	Hardin County	Haywood County	Service Area Total-17 Counties	State of TN Total
Total Population-Current Year-2015	26,075	18,044	533,505	6,649,438
Total Population-Projected Year-2019	26,310	18,032	538,691	6,894,997
Total Population-% change	.30%	0%	1.0%	3.7%
*Target Population-Current Year-2015	5,508	2,821	93,016	1,012,937
*Target Population-Projected Year-2019	5,900	3,136	99,462	1,134,565
Target Population-% change	7.1%	11.2%	6.9%	12.0%
Target Population-Projected Year as % of Total	22.4%	17.4%	18.4%	16.5%
Median Age	43.5	40.5		38.6
Median Household Income	$33,622	$34,542		$44,298
TennCare Enrollees (Aug 15)	7,259	5,941	137,810	1,447,657
TennCare Enrollees as % of Total	27.8%	32.9%	25.8%	21.8%
Persons Below Poverty Level	5,795	3,869	103,505	1,101,732
Persons Below Poverty Level as % of Total	22.2%	21.4%	19.4%	16.6%

**Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. For projects not having a specific target population use the Age 65+ population for the target population variable.*

Demographic Variable/Geographic Area	Henderson County	Henry County	Service Area Total-17 Counties	State of TN Total
Total Population-Current Year-2015	28,279	32,766	533,505	6,649,438
Total Population-Projected Year-2019	28,743	33,015	538,691	6,894,997
Total Population-% change	1.6%	.76%	1.0%	3.7%
*Target Population-Current Year-2015	4,892	7,033	93,016	1,012,937
*Target Population-Projected Year-2019	5,371	7,351	99,462	1,134,565
Target Population-% change	9.8%	4.5%	6.9%	12.0%
Target Population-Projected Year as % of Total	18.7%	22.3%	18.4%	16.5%
Median Age	39.9	44.5		38.6
Median Household Income	$38,280	$36,950		$44,298
TennCare Enrollees (Aug 15)	7,168	8,112	137,810	1,447,657
TennCare Enrollees as % of Total	25.3%	24.8%	25.8%	21.8%
Persons Below Poverty Level	5,169	6,075	103,505	1,101,732
Persons Below Poverty Level as % of Total	18.3%	18.5%	19.4%	16.6%

**Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. For projects not having a specific target population use the Age 65+ population for the target population variable.*

Demographic Variable/Geographic Area	Lauderdale County	McNairy County	Service Area Total-17 Counties	State of TN Total
Total Population-Current Year-2015	27,264	26,755	533,505	6,649,438
Total Population-Projected Year-2019	27,135	27,509	538,691	6,894,997
Total Population-% change	-.47%	2.8%	1.0%	3.7%
*Target Population-Current Year-2015	3,922	5,194	93,016	1,012,937
*Target Population-Projected Year-2019	4,292	5,568	99,462	1,134,565
Target Population-% change	9.4%	7.2%	6.9%	12.0%
Target Population-Projected Year as % of Total	15.8%	20.2%	18.4%	16.5%
Median Age	36.4	41.9		38.6
Median Household Income	$32,326	$33,452		$44,298
TennCare Enrollees (Aug 15)	7,920	7,744	137,810	1,447,657
TennCare Enrollees as % of Total	29.0%	28.9%	25.8%	21.8%
Persons Below Poverty Level	6,463	5,786	103,505	1,101,732
Persons Below Poverty Level as % of Total	23.7%	21.6%	19.4%	16.6%

**Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. For projects not having a specific target population use the Age 65+ population for the target population variable.*

Demographic Variable/Geographic Area	Madison County	Obion County	Service Area Total-17 Counties	State of TN Total
Total Population-Current Year-2015	99,971	31,365	533,505	6,649,438
Total Population-Projected Year-2019	101,279	31,218	538,691	6,894,997
Total Population-% change	1.3%	-.47%	1.0%	3.7%
*Target Population-Current Year-2015	14,747	5,995	93,016	1,012,937
*Target Population-Projected Year-2019	16,289	6,347	99,462	1,134,565
Target Population-% change	10.5%	5.9%	6.9%	12.0%
Target Population-Projected Year as % of Total	16.1%	20.3%	18.4%	16.5%
Median Age	37.0	41.5		38.6
Median Household Income	$41,617	$39,467		$44,298
TennCare Enrollees (Aug 15)	24,557	7,914	137,810	1,447,657
TennCare Enrollees as % of Total	24.6%	25.2%	25.8%	21.8%
Persons Below Poverty Level	18,872	5,553	103,505	1,101,732
Persons Below Poverty Level as % of Total	18.9%	17.7%	19.4%	16.6%

**Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. For projects not having a specific target population use the Age 65+ population for the target population variable.*

Demographic Variable/Geographic Area	Weakley County		Service Area Total-17 Counties	State of TN Total
Total Population-Current Year-2015	38,790		533,505	6,649,438
Total Population-Projected Year-2019	39,709		538,691	6,894,997
Total Population-% change	2.4%		1.0%	3.7%
*Target Population-Current Year-2015	5,933		93,016	1,012,937
*Target Population-Projected Year-2019	6,292		99,462	1,134,565
Target Population-% change	6.1%		6.9%	12.0%
Target Population-Projected Year as % of Total	15.8%		18.4%	16.5%
Median Age	36.9			38.6
Median Household Income	$35,273			$44,298
TennCare Enrollees (Aug 15)	7,468		137,810	1,447,657
TennCare Enrollees as % of Total	19.3%		25.8%	21.8%
Persons Below Poverty Level	6,753		103,505	1,101,732
Persons Below Poverty Level as % of Total	17.4%		19.4%	16.6%

**Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for the discontinuance of OB services would mainly affect Females Age 15-44; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. For projects not having a specific target population use the Age 65+ population for the target population variable.*

Sources: Tennessee Department of Health. Tennessee Population Projections, 2010-2020; U.S. Department of Commerce, Bureau of the Census, State and County QuickFacts, American Community Survey, 2009-2013 5-Year Estimates; U.S. Department of Commerce, Bureau of the Census, Poverty Status in past 12 Months, American Community Survey, 2012 1-Year Estimates; U.S. Department of Commerce, Bureau of the Census, American Community Survey Demographic Housing Estimates 2009-2013 5-Year Estimates.

4. B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: Both West Tennessee Healthcare and HealthSouth Corporation are dedicated to meeting the special needs of these populations and have an established history of providing high quality healthcare that is accessible to all segments of the community. West Tennessee Healthcare has a unique community role that includes not only the responsibility to improve the health of its communities and practice good citizenship, but also to assure that the business of delivering healthcare has no adverse environmental, safety, or public health effect. HealthSouth Corporation shares in this commitment to the communities served.

Because of the nature of the health care services provided, the patient population treated at West Tennessee Rehabilitation Center is heavily skewed toward the elderly and the infirm. The special needs of the elderly are a vital concern in the West Tennessee Rehabilitation Center service area. According to data from the Tennessee Department of Health, individual age 65 and older represent 17.4 percent of the seventeen (17) county service area population, or 93,016 of the estimated 533,505 residents. This compares to 15.2 percent for the entire state. Because of differences in life spans, more women than men are treated at the hospital. West Tennessee Rehabilitation Center recognizes the special needs of these vulnerable populations.

Persons with limited sources of income and no insurance often have complex rehabilitation cases due to their historical lack of primary medical care. They also may lack some of the personal support systems proven beneficial to the rehabilitation process. Neither West Tennessee Healthcare facilities or HealthSouth Corporation discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment or participation in its programs, services and activities, or in employment. Existing policies for charity care and the treatment of the underserved population will remain in place. In addition, both West Tennessee Healthcare and HealthSouth Corporation collect and utilize all relevant data and information to improve each organization's performance in providing superior healthcare outcomes, service delivery results, and functional status.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response: West Tennessee Rehabilitation Center is the only provider of inpatient rehabilitation services in the primary service area of West Tennessee Healthcare. HealthSouth Cane Creek is located in its secondary service area. Occupancy information for the facility is provided in the response to the next question.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: The following tables contain historical and projected utilization data for West Tennessee Rehabilitation Center. The projections for 2018 and 2019 are based upon the growth history of the existing unit and knowledge of the market garnered through many years of providing inpatient rehabilitation services in the community and surrounding areas.

Historical data for FY2013 through FY2015

	FY2013	FY2014	FY2015
Patient Days	12,176	12,467	13,560
Average Occupancy (Staffed)	69.3%	71.2%	77.4%
Discharges	813	945	1,038
Average Daily Census	33.4	34.2	37.2

Projections for FY2018 and FY2019

	FY2018	FY2019
Patient Days	14,080	14,846
Average Occupancy (Staffed)	80.4%	84.7%
Discharges	1,115	1,165
Average Daily Census	38.6	40.7

Economic Feasibility

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

- ***All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)***

  RESPONSE: The fee is $45,000, which is the maximum based on the project costs.

- ***The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.***

  RESPONSE: The most recent appraisal of 616 West Forest Avenue was conducted by David Horton & Associates, Inc. of Jackson, Tennessee. The appraisal of the 5.59 acres was $129,259 per acre for a total of $722,559.

The terms of the ground lease are $28,000 per acre for 5.59 acres. The term is 35 years with a 2 percent increase each year. The value of the ground lease is $8,138,158.

The amount of $3,045,315 is projected for demolition of the current structure and site preparation for the new building.

Architectural and engineering fees are $1,908,000 or 5.6 percent of the project costs of $34,284,180.

Legal, administrative fees and preparation of the certificate of need is $100,000.

- **The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.**

Fixed equipment is $2,304,022 and moveable equipment is $3,850,000.

Other expenses is the cost of the ACR-IT Medical Records estimated to be $935,000.

- **For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.**

RESPONSE: Construction costs are estimated to be $12,730,623. The average cost per square foot is $214.14. A letter from Frederick & Associates-Architects, Inc. is included in Attachment Section C. Economic Feasibility 1.

The amount for contingency is $1,273,062 or 10 percent of construction costs.

Response: Please see the Project Costs Chart on the following page.
Insert Project Cost Chart Here

Received 10/14/15
11:00 a.m

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$ 1,908,000
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$ 100,000
	3.	Acquisition of Site	
	4.	Preparation of Site	$ 3,045,315
	5.	Construction Costs	$12,730,623
	6.	Contingency Fund	$ 1,273,062
	7.	Fixed Equipment (Not included in Construction Contract)	$ 2,304,022
	8.	Moveable Equipment (List all equipment over $50,000)	$ 3,850,000
	9.	Other (Specify) ACE-IT Med Records	$ 935,000
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	
	2.	Building only	
	3.	Land only	$ 8,138,158
	4.	Equipment (Specify) _____	
	5.	Other (Specify) _____	
C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)		$34,284,180
E.	CON Filing Fee		$ 45,000
F.	Total Estimated Project Cost (D+E)		
		TOTAL	$34,329,180

2. **Identify the funding sources for this project. Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)**

__ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

__ D. Grants--Notification of intent form for grant application or notice of grant award; or

X E. Cash Reserves--Appropriate documentation from Chief Financial Officer.

__ F. Other—Identify and document funding from all other sources.

Response: The project will be funded from cash reserves by the participants in the joint venture, Jackson-Madison County Hospital and HealthSouth Corporation. HealthSouth's intent and capacity to fund the project is documented in a letter from Mr. Edmund Fay, Senior Vice President of HealthSouth Corporation. The funding from cash reserves of Jackson-Madison County General Hospital is documented in a letter from MR. Jeff Blankenship. These letters and each participant's financial statements are provided in the attachments labeled **Section C – Economic Feasibility – 2** and **Section C – Economic Feasibility – 10**.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

Response: The project's $214.14 cost per SF cost for new construction is based on research conducted by HealthSouth's architect into recent and local construction costs. This is slightly lower than the median costs for hospital construction projects approved by the HSDA for the years 2012-2014. This information is presented in the following table.

	2012-2014 Median	**West Tennessee Rehabilitation Center**
New Construction	$259.66/SF	$214.14

4. Complete Historical and Projected Data Charts on the following two pages--Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the Proposal Only (i.e., if the

application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

Response: Please see the Historical and Projected Data Charts on the following pages.

HISTORICAL DATA CHART

Received 10/14/15 11:00 a.m

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).(For the 48 beds at Jackson-Madison County General Hospital)

		YearFY2013	YearFY2014	YearFY2015
A.	Utilization Data (patient days)	12,176	12,467	13,560
B.	Revenue from Services to Patients			
1.	Inpatient Services	$18,382,421	$20,286,350	$23,523,025
2.	Outpatient Services	111,179	101,238	119,577
3.	Emergency Services			
4.	Other Operating Revenue (Specify) _____	50,152	52,796	61,082
	Gross Operating Revenue	**$18,543,752**	**$20,440,384**	**$23,703,684**
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$5,078,110	$6,640,422	$7,143,145
2.	Provision for Charity Care	612,438	500,955	616,890
3.	Provisions for Bad Debt	370,220	197,969	343,082
	Total Deductions	**$ 6,060,768**	**$ 7,339,346**	**$ 8,103,118**
NET OPERATING REVENUE		**$12,482,984**	**$13,101,038**	**$15,600,566**
D.	Operating Expenses			
1.	Salaries and Wages	$ 5,897,795	$ 6,119,455	$ 6,704,806
2.	Physician's Salaries and Wages			
3.	Supplies	124,365	136,301	158,137
4.	Taxes			
5.	Depreciation	65,590	64,326	74,347
6.	Rent			
7.	Interest, other than Capital			
8.	Management Fees:			
	a. Fees to Affiliates			
	b. Fees to Non-Affiliates	815,413	1,010,670	1,139,194
9.	Other Expenses – Specify on Page 23	185,294	258,868	241,572
	Total Operating Expenses	**$ 7,088,456**	**$ 7,589,620**	**$ 8,318,056**
E.	Other Revenue (Expenses) – Net (Specify) _____	$(3,765,378)	$(3,964,627)	$(4,101,816)
NET OPERATING INCOME (LOSS)		**$ 1,629,149**	**$ 1,546,791**	**$ 3,180,694**
F.	Capital Expenditures			
1.	Retirement of Principal	$	$	$
2.	Interest			
	Total Capital Expenditures	**$ 0**	**$ 0**	**$ 0**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$1,629,149**	**$1,546,791**	**$3,180,694**

Received 10/14/15
11:00 a.m

HISTORAL DATA CHART – OTHER EXPENSES

OTHER EXPENSES CATEGORIES	YearFY2013	YearFY2014	YearFY2015
1. Recruiting	81,398	137,424	129,257
2. Cost Allocations	65,427	74,870	83,356
3. Copy Expense	11,574	22,679	11,679
4. IT Maintenance Contracts	5,682	6,199	6,199
5. Telecommunications	2,523	4,520	3,827
6. Taxes	800	1,200	1,200
7. Other	17,890	11,976	6,054
Total Other Expenses	**$1,000,707**	**$1,269,538**	**$1,380,766**

Received 10/14/15
11:00 a.m

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year2018	Year2019
A.	Utilization Data (discharge days)	14,080	14,846
B.	Revenue from Services to Patients		
1.	Inpatient Services	$25,410,402	$28,239,259
2.	Outpatient Services		
3.	Emergency Services		
4.	Other Operating Revenue (Specify) _____		
	Gross Operating Revenue	**$25,410,402**	**$28,239,259**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 7,952,694	$ 8,838,041
2.	Provision for Charity Care	686,843	763,307
3.	Provisions for Bad Debt	197,752	219,767
	Total Deductions	**$ 8,837,289**	**$ 9,821,115**
NET OPERATING REVENUE		**$16,573,113**	**$18,418,144**
D.	Operating Expenses		
1.	Salaries and Wages	$8,809,612	$9,051,638
2.	Physician's Salaries and Wages	148,722	151,697
3.	Supplies	893,142	960,595
4.	Taxes	777,474	897,788
5.	Depreciation	1,494,397	1,814,943
6.	Rent	156,520	159,650
7.	Interest, other than Capital		
8.	Management Fees		
a.	Fees to Affiliates	1,362,667	920,907
b.	Fees to Non-Affiliates		
9.	Other Expenses – Specify on Page 23	2,625,731	2,782,548
	Total Operating Expenses	**$16,268,265**	**$16,739,766**
E.	Other Revenue (Expenses) – Net (Specify) _____	$	$
NET OPERATING INCOME (LOSS)		**$ 304,848**	**$ 1,678,378**
F.	Capital Expenditures		
1.	Retirement of Principal	$	$
2.	Interest		
	Total Capital Expenditures	**$**	**$**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 304,848**	**$ 1,678,378**

PROJECTED DATA CHART – OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Equipment Rental & Maintenance	$ 398,447	$ 428,539
2. Utilities/Telephone (annual)	345,557	352,468
3. Contract Services	756,433	813,562
4. Other Variable Expenses	490,286	527,315
5. CIS Expense	72,000	73,440
6. Insurance/Bonding	233,331	250,953
7. Other Fixed	329,677	336,271
Total Other Expenses	**$2,625,731**	**$2,782,548**

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response: The following table provides the estimated average gross charge, average deduction from operating revenue, and the average net charge for the first calendar year after implementation of the proposed project.

	FY2018
Average Gross Charge	$1,804/day
Average Deduction	$628/day
Average Net Patient Revenue	$1,176/day

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: For FY2015, the average charge per day for patient care was $1,735. The projected charge for FY2018, the first year after implementation of the project, is $1,804 per patient day.

6. B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: West Tennessee Rehabilitation Center and HealthSouth Cane Creek are the only providers of inpatient rehabilitation services in the service area of West Tennessee Healthcare. For 2013, the average charge per patient day for HealthSouth Cane Creek was $1,323.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response: The projected utilization rates are incremental to current operations, and the project will result in a small increase in patient charges.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response: As an existing provider of health care services, West Tennessee Rehabilitation Center is currently financially viable. As stated in the letters provided by Jeff Blankenship, Vice President and Chief Financial Officer, Jackson-Madison County General Hospital District and Ed Fay, Senior Vice President, HealthSouth Corporation, in the response to the attachment labeled **Section C – Economic Feasibility – 2**, HealthSouth Corporation has ample financial resources to support the facility both during the implementation of the project and afterward. The Projected Data Chart indicates the facility will achieve positive financial results in the first year.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response: The facility will participate in Medicare and TennCare/Medicaid, and also provides services to medically indigent patients. The following table lists the amounts and percentage of revenue for each category for the first year following completion of the project.

	Medicare	TennCare/Medicaid	Charity
Gross Revenue	$19,055,100	$565,022	$1,565,982
% of Gross Revenue	75.0%	2.2%	6.2%

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response: Please see the attachment labeled **Section C – Economic Feasibility – 10** for a copies of the latest audited financial statements for West Tennessee Healthcare and the most recent 10-K filing for HealthSouth Corporation.

11. A. Describe all alternatives to this project that were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response: The applicant considered alternatives to the proposed project, including remaining in the current location. However, it was determined that the construction of a new facility with modern, state-of-the-art patient rooms was the optimal choice by providing an environment dedicated solely to the provision of inpatient rehabilitation and fostering an environment solely dedicated to returning patients to the highest functional level policy. Moving inpatient rehabilitation services to a new freestanding location will permit the existing space at Jackson-Madison County Hospital to be used to provide other healthcare services.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response: The applicant considered alternatives to new construction and determined that construction of a new facility with modern, state-of-the-art patient rooms was the optimal choice.

Contribution to the Orderly Development of Health Care

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

Response: As an existing provider of inpatient rehabilitation services, Jackson-Madison has in place contractual and working relationships with existing health care providers within its service area, including transfer agreements with acute care hospitals, referral relationships with nursing homes and home care organizations, and working relationships with other health care providers to ensure the efficient delivery of health care services to its patient population. The applicant plans to have similar arrangements. The following are existing transfer agreements.

Methodist Healthcare - Memphis Hospitals
Douglas Health and Rehab Center
Bolivar General Hospital; Inc.
McKenzie Medical Center
Parkway Regional Hospital
Bolivar General Hospital; Inc.

Vanderbilt University
Camden Healthcare and Rehabilitation Center
Camden General Hospital
Decatur County General Hospital
Baptist Memorial Hospital-Union City
Camden General Hospital
Henderson County Community Hospital
DDC Surgery Center
Humboldt Manor Nursing Center
Tennessee State Veterans Home
Dyer Nursing Home
Humboldt Nursing Home
Magnolia Regional Health Center
Maplewood Healthcare Center
Volunteer Community Hospital
Laurelwood Healthcare Center
Total Renal Care; Inc.
Chester County Health Care; Inc
Bailey Park Community Living Center
McNairy Regional Hospital
Physicians Surgery Center
Total Renal Care; Inc
Methodist Healthcare-Volunteer Hospital
Morningside
Vanayer Manor & Rehab
Jackson Tennessee Hospital Company; LLD
Vanderbilt University
Total Renal Care; Inc
Henry County Medical Center
Baptist Memorial Hospital-Huntingdon
Union City Nursing & Rehab
Le Bonheur Children's Medical Center
Behavioral Healthcare Center at Martin; LLC
Hardin Medical Center
Mid-South Heart Center PC
Oak Hills Behavioral Center
Lauderdale Community Hospital
Digestive Disease Clinic Surgery Center
West Tennessee Transitional Care; Inc
Mission Convalescent Home
Vanderbilt University
Forest Cove Manor
Tennessee State Veterans Home
Jackson Tennessee Hospital Company; LLD
Northbrook Healthcare and Rehab Center

Milan Health Care
Milan General Hospital
NHC Healthcare; Inc
Pathways of Tennessee; Inc
Jackson Halfway House
Dyersburg Regional Medical Center

The facility maintains working relationships with area physicians to identify and refer patients whose clinical conditions merit comprehensive inpatient rehabilitation in a hospital setting. Jackson-Madison currently contracts with four (4) Health Maintenance Organizations (HMO) and fourteen (14) Preferred Provider Organizations (PPO). The applicant expects these relationships to continue.

ACS Consulting
Aetna Health Plans
Allsteel, Inc.
Americhoice UHC
Blue Care
Blue Cross Blue Shield of TN - Network P
Blue Cross Blue Shield of TN - Network S
Blue Advantage
Cigna Health Plans
Corrections Corporation of America
Correctional Medical Systems
LifeSynch
Corvel
Coventry
CoverTN
Cracker Barrel
Crawford & Co.
Department of Human Services
Dyersburg City Schools
Evolutions Health Care
Falcon Plastics
FEI
First Health Plan
GEHA/PPO USA
Health Partners - WTH, THC
Health Payors Organization
Healthlink of Missouri
Interplan Health Group
JACOA
Magna/Milan-Seating Systems
Magellan
Masco Corporation of America
Methodist (Clergy)
Metropolitan Behavioral Counseling
Milan Express Company
Mississippi RiverKings
National Rural Electric Cooperative Association
Network Synergy Group
OccuComp
Pathways WTHN
Private Healthcare Systems
Sanford Health Plan
Tennessee Breast & Cervical Cancer Early Detection Program
TennCare Select
Tennessee Department of Human Services Rehab Programs
Tennessee Healthcare
Union Pacific Railroad Retiree Benefit Program
United Healthcare
United Healthcare/Americhoice/UBH
USA MCO
Value Options for BlueCare/TennCare Select
Value Options for Tricare Military
Wellmark
Western Mental Health

HealthSpring
Humana Choice Care
Humana Military Healthcare Services (TriCare)
Humana Medicare Advantage
Williams Steel
Work Partners
Underwriters Service Corporation

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response: The project will have a positive effect on the health care system by providing a new state-of-the-art care setting designed to permit efficiencies in the delivery of patient care and lower overall health care costs to the system. West Tennessee Rehabilitation Center is the only existing provider in its primary service area and does not seek approval for new additional health care services. The other facility in the service area, HealthSouth Cane Creek, is part of the contemplated joint venture, and as such, there will be no negative impact on other existing providers.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Response: The following table presents the projected staffing at West Tennessee Rehabilitation Center after implementation of this project.

Position	FTE	Salary Range	Entry	Tennessee Median	Experienced
Administrator	1.0	$54.90-$93.33			
Director of Nursing	1.0	$41.53-$70.60			
Controller	1.0	$31.96-$54.02	$ 19.51	$ 26.35	$ 35.34
Director of Marketing	1.0	$31.96-$54.02	$ 19.31	$ 23.12	$ 47.52
Director of Therapy	1.0	$41.53-$70.60			
Director of Quality	1.0	$28.06-$47.14	$ 30.28	$ 46.76	$ 66.16
Rehab Liaison	1.0	$24.64-$41.15			
Admission Supervisor	1.0	$18.79-$31.32	$ 9.84	$ 13.40	$ 16.20
Admission liaison	1.0	$21.53-$35.88			
Other Administration	1.0	$14.62-$24.37			
HR Director	1.0	$28.06-$47.14	$ 16.78	$ 35.70	$ 43.35
Receptionist	1.0	$10.71-$17.85	$ 9.39	$ 11.48	$ 13.02
Nurse Manager	1.0	$28.06-$47.14			
Registered Nurse	1.0	$21.53-$35.88	$ 20.37	$ 23.83	$ 27.10
Licensed Practical Nurse	1.0	$16.60-$27.67	$ 12.71	$ 16.09	$ 17.95
Nurse Aide	1.0	$9.63-$16.05	$ 8.74	$ 16.22	$ 17.47
RN Infection Control/ Employee Health	1.0	$21.53-$35.88			
Unit Clerk/Secretary	1.0	$10.71-$17.85	$ 9.39	$ 12.52	$ 16.06
Physical Therapist	1.0	$28.06-$47.14	$ 31.15	$ 37.61	$ 43.68
Speech Therapist	1.0	$24.64-$41.15	$ 19.16	$ 29.35	$ 36.25
Occupational Therapist	1.0	$28.06-$47.14	$ 31.46	$ 37.01	$ 14.63
Therapy Aides	1.0	$10.71-$17.85	$ 14.30	$ 10.75	$ 11.15
Therapy Assistants	1.0	$18.79-$31.32	$ 9.32	$ 11.97	$ 13.85
Director Case Managemer	1.0	$31.96-$54.02	$ 18.33	$ 27.66	$ 36.75
Case Managers	1.0	$21.53-$35.88	$ 14.86	$ 21.31	$ 25.38
Case Management Assts	1.0	$12.04-$20.06			
Pharmacist	1.0	$41.53-$70.60	$ 37.81	$ 58.13	$ 60.85
Pharmacy Tech	1.0	$10.71-$17.85	$ 10.00	$ 12.38	$ 14.56
Supervisor Respiratory Therapist	1.0	$24.64-$41.15			
Respiratory Therapist	1.0	$21.53-$35.88	$ 16.63	$ 19.17	$ 21.99
Central Supply Clerk	1.0	$10.71-$17.85	$ 8.13	$ 9.88	$ 12.15

Position	FTE	Salary Range	Entry	Tennessee Median	Experienced
Supervisor Dietary	1.0	$21.53-$35.88			
Cook	1.0	$10.71-$17.85	$ 11.49	$ 13.85	$ 16.78
Dietary Aide	1.0	$8.15-$13.59	$ 8.08	$ 10.22	$ 13.11
Dietician	1.0	$18.79-$31.32	$ 13.48	$ 19.63	$ 26.06
Supervisor Housekeeping	1.0	$18.79-$31.32	$ 10.32	$ 11.74	$ 16.92
Housekeepers	1.0	$8.15-$13.59	$ 8.10	$ 9.15	$ 11.17
Manager Plant Operations	1.0	$31.96-$54.02	$ 19.07	$ 27.12	$ 32.73
Maintenance Assistance	1.0	$12.99-$21.65	$ 11.04	$ 18.53	$ 21.53
HIMS Director	1.0	$18.79-$31.32	$ 23.74	$ 38.21	$ 44.48
HIMS Clerk	1.0	$16.60-$27.67	$ 8.20	$ 10.31	$ 11.66

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response: Jackson-Madison County General Hospital currently employs a professional staff for the West Tennessee Rehabilitation Center. The applicant anticipates being able to recruit additional staff without difficulty, if necessary. On-going staff recruitment and training is accomplished as needed through:

- Corporate recruitment programs (as implemented through its extensive network at national and regional levels) which aid in locating qualified administrative, clinical, and nursing leadership;
- National training programs and local in-services about new programs;
- Student scholarship programs;
- Newspaper and journal advertisements (local, state-wide, and national);
- Internet advertising;

- Hiring incentives and bonuses; and,
- Incentives for current staff to refer qualified applicants.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

Response: The applicant so verifies.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response: The applicant intends that West Tennessee Rehabilitation Center will continue to serve as a teaching site for students pursuing careers in therapy, nursing, and other health-related professions. The other participant in the joint venture, HealthSouth Corporation, maintains clinical teaching affiliations with over 1,100 universities, colleges, and technical schools throughout the United States to provide physical therapy, occupational therapy, speech language pathology, and nursing students the opportunity to participate in clinical and technical rotations at HealthSouth affiliated facilities around the country.

Currently, Jackson-Madison County General Hospital serves as a clinical site for the University of Tennessee Family Medical Residency Program. The Hospital also provides training for students in nursing (BSN) programs at Union University in Jackson, The University of Tennessee at Martin, The University of Memphis, Freed Hardeman University, and Bethel University; Associate Degree programs at Jackson State Community College and Dyersburg State Community College; and Licensed Practical Nursing Programs at Tennessee Technology Centers.

Jackson General is a clinical site for the certified nurse anesthetist (CRNA) and Pharmacy Programs at Union University.

Jackson General also has relationships with the Allied Health programs at Jackson State Community College and the Tennessee Technology Centers.

Social work training is offered for students from Freed Hardeman University, University of Tennessee at Martin, University of Tennessee at Memphis, and Union University.

7. a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

Response: The applicant so verifies.

7. (b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Response: The applicant will receive licensure, certification, and/or accreditation from the following entities: [confirm]

Licensure: Board for Licensure of Healthcare Facilities, Tennessee Department of Health
Certification: Medicare Certification from CMS; TennCare Certification from Tennessee Department of Health
Accreditation: The Joint Commission

7. (c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Response: Not applicable (N/A)

7. (d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response: Not applicable (NA)

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Response: There are no final orders or judgments against professional licenses held by the applicants or any entities or persons with more than a 5% ownership interest in the applicants.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

Response: There are no final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

Response: The applicant will provide the requested data to the Tennessee Health Services and Development Agency consistent with Federal HIPAA requirements. Additionally, the applicant will submit a Joint Annual Report (JAR) to the Tennessee Department of Health.

Received 10/14/15
11:00 a.m.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

The full page of The Jackson Sun is attached.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Please note that Tennessee Code Annotated 68-11-1607(c)(3) states that "...Within ten (10) days of filing an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the member of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

Please provide this documentation.

Response: Not Applicable

Received 10/14/15
11:00 a.m.

731-423-0300

Continued to next column

0000786101

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that West Tennessee Rehabilitation Center owned by West Tennessee Rehabilitation Hospital, LLC with an ownership type of limited liability company and to be managed by HealthSouth Corporation intends to file an application for a Certificate of Need for establishing a 48 bed inpatient rehabilitation hospital at 616 West Forest Avenue, Jackson, Tennessee. The project will require approximately 59,450 square feet of new construction, and the estimated cost of the project is $34,329,180. The project will not involve the purchase of major medical equipment. The applicant is jointly owned by the Jackson-Madison County General Hospital District and HealthSouth Corporation. Upon completion of the project, Jackson-Madison County General Hospital will delicense its 48 inpatient rehabilitation beds. The anticipated date of filing the application is October 14, 2015. The contact person for this project is Victoria S. Lake, Director, who may be reached at Jackson-Madison County General Hospital, 620 Skyline Drive, Jackson, TN 38301, (731) 984-2160.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.

Response: Please see the attached Project Completion Forecast Chart on the following page.

2. If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.

Response: Not applicable. The applicant anticipates completing the project within the period of validity.

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): January 2016

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase		DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1.	Architectural and engineering contract signed	1	February 2016
2.	Construction documents approved by the Tennessee Department of Health	220	September 2016
3.	Construction contract signed	5	September 2016
4.	Building permit secured	5	September 2016
5.	Site preparation completed	31	October 2016
6.	Building construction commenced	31	October 2016
7.	Construction 40% complete	182	March 2017
8.	Construction 80% complete	122	June 2017
9.	Construction 100% complete (approved for occupancy)	122	September 2017
10.	*Issuance of license	5	September 2017
11.	*Initiation of service	31	October 2017
12.	Final Architectural Certification of Payment	31	October 2017
13.	Final Project Report Form (HF0055)	31	October 2017

*** For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

Received 10/14/15
11:00 a.m.

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Madison

Victoria S. Lake, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Victoria S. Lake, Director
Market Research + Community Development
SIGNATURE/TITLE

Sworn to and subscribed before me this 12 day of October (Month), 2015 (Year) a Notary Public in and for the County/State of Madison / Tennessee.

NOTARY PUBLIC

My commission expires September 21 (Month/Day), 2016 (Year).

RANDALL L HAMPTON
STATE OF TENNESSEE NOTARY PUBLIC
MADISON COUNTY TN

Received 10/14/15
11:00 a.m.

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the The Jackson Sun (Name of Newspaper) which is a newspaper of general circulation in Madison (County), Tennessee, on or before October 10 (Month / day), 2015 (Year) for one day.

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: West Tennessee Rehabilitation Center (Name of Applicant) (Facility Type-Existing)

owned by: West Tennessee Rehabilitation Hospital, LLC with an ownership type of: limited liability company and to be managed by: HealthSouth Corporation intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

establishing a 48 bed inpatient rehabilitation hospital at 616 West Forest Avenue, Jackson, Tennessee. The project will require approximately 59,450 square feet of new construction, and the estimated cost of the project is $34,329,180. The project will not involve the purchase of major medical equipment. The applicant is jointly owned by the Jackson-Madison County General Hospital District and HealthSouth Corporation. Upon completion of the project, Jackson-Madison County General Hospital will delicense its 48 inpatient rehabiltiation beds.

The anticipated date of filing the application is: October 14, 2015

The contact person for this project is Victoria S. Lake (Contact Name), Director (Title)

who may be reached at: Jackson-Madison County General Hospital (Company Name), 620 Skyline Drive (Address)

Jackson (City), TN (State), 38301 (Zip Code), (731) 984-2160 (Area Code / Phone Number)

[signature] (Signature), 10/08/15 (Date), Vicki.Lake@WTH.org (E-mail Address)

==========

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

==========

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

PUBLICATION OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than two (2) columns by two (2) inches.

==========

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

West Tennessee Rehabilitation Center
(Name of Applicant) (Facility Type-Existing)

owned by: West Tennessee Rehabilitation Hospital, LLC with an ownership type of limited liability company and to be managed by: HealthSouth Corporation intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

establishing a 48 bed inpatient rehabilitation hospital at 616 West Forest Avenue, Jackson, Tennessee. The project will require approximately 59,450 square feet of new construction, and the estimated cost of the project is $34,329,180. The project will not involve the purchase of major medical equipment. The applicant is jointly owned by the Jackson-Madison County General Hospital District and HealthSouth Corporation. Upon completion of the project, Jackson-Madison County General Hospital will delicense its 48 inpatient rehabiltiation beds.

The anticipated date of filing the application is: October 14, 20 15

The contact person for this project is Victoria S. Lake (Contact Name) Director (Title)

who may be reached at: Jackson-Madison County General Hospital (Company Name) 620 Skyline Drive (Address)

Jackson (City) TN (State) 38301 (Zip Code) (731) 984-2160 (Area Code / Phone Number)

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

Attachment A.3.
Ownership

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "WEST TENNESSEE REHABILITATION HOSPITAL, LLC", FILED IN THIS OFFICE ON THE EIGHTH DAY OF OCTOBER, A.D. 2015, AT 3:13 O`CLOCK P.M.

Jeffrey W. Bullock, Secretary of State

5845408 8100
SR# 20150437995

Authentication: 10207436
Date: 10-08-15

You may verify this certificate online at corp.delaware.gov/authver.shtml

CERTIFICATE OF FORMATION
OF
WEST TENNESSEE REHABILITATION HOSPITAL, LLC

1. The name of the limited liability company is West Tennessee Rehabilitation Hospital, LLC.

2. The address of its registered office in the State of Delaware is: Corporation Trust Center, 1209 Orange Street, in the City of Wilmington, Delaware 19801. The name of its registered agent at such address is The Corporation Trust Company.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation of West Tennessee Rehabilitation Hospital, LLC this 8th day of October, 2015.

John P. Whittington, Authorized Person

State of Delaware
Secretary of State
Division of Corporations
Delivered 03:13 PM 10/08/2015
FILED 03:13 PM 10/08/2015
SR 20150437995 - File Number 5845408

LIMITED LIABILITY COMPANY AGREEMENT OF WEST TENNESSEE REHABILITATION HOSPITAL, LLC

This LIMITED LIABILITY COMPANY AGREEMENT OF WEST TENNESSEE REHABILITATION HOSPITAL, LLC (this "Agreement"), is entered into and effective as of October 8, 2015 (the "Effective Date"), by and between **HEALTHSOUTH WEST TENNESSEE HOLDINGS, LLC**, a Delaware limited liability company ("HLS") and Jackson Madison County General Hospital District, d/b/a **WEST TENNESSEE HEALTHCARE** a Tennessee governmental entity ("WTH" and, together with HLS, the "Members"). The undersigned Members hereby form a limited liability company pursuant to and in accordance with the Delaware Limited Liability Company Act (the "Act"), and hereby agree as follows:

1. Name. The name of the limited liability company formed hereby (the "LLC") is WEST TENNESSEE REHABILITATION HOSPITAL, LLC.

2. Purpose and Powers. The purpose of the LLC is to (a) design, develop, build and operate a rehabilitation hospital in Jackson, Tennessee (the "New Rehabilitation Hospital"), (b) own and operate a rehabilitation hospital in Martin, Tennessee, and (c) engage in any and all other lawful activities to which the Members agree. The LLC shall possess and may exercise all of the powers and privileges granted by the Act or by any other law or by this Agreement, together with any powers incidental thereto, so far as such powers and privileges are necessary or convenient to the conduct, promotion or attainment of the business purposes or activities of the LLC.

3. Offices.

(a) Principal Office. The principal office of the LLC, and such additional offices as the Members may determine to establish, shall be located at such place or places inside or outside the State of Delaware as the Members may designate from time to time.

(b) Registered Office; Registered Agent. The registered office of the LLC in the State of Delaware is located at 1209 Orange Street, Wilmington, Delaware 19801. The registered agent of the LLC for service of process at such address is The Corporation Trust Company. The Members may change such registered office or registered agent at any time.

4 Members.

(a) Simultaneously with the execution and delivery of this Agreement, HLS and WTH are admitted as the members of the LLC. The names and addresses of the Members are set forth on Exhibit A.

(b) The Members, acting unanimously, may admit additional

members of the LLC upon such terms and conditions, at such time or times, and for such capital contributions as shall be determined by all of the Members. In connection with any such admission, the Members shall amend Exhibit A to reflect the name, address and capital contribution of each such additional member.

5. Term. The term of the LLC shall be perpetual unless the LLC is dissolved and terminated in accordance with Section 12 of this Agreement.

6. Capital Contributions; Capital Accounts.

(a) Initial Capital Contributions. Simultaneously with the execution and delivery of this Agreement, the Members have made the contributions to the capital of the LLC set forth beside their respective names on Exhibit A (as to each, its "Initial Capital Contribution").

(b) Additional Capital Contributions. No Member is required to make any contribution of property of money to the LLC in excess of its respective Initial Capital Contribution.

(c) Capital Accounts. An separate account shall be established in the LLC's books for each Member and transferee (each, a "Capital Account") in accordance with the rules of Section 704 of the Internal Revenue Code of 1986, as amended, and the regulations thereunder.

7. Percentage Interest; Allocations of Profits and Losses.

(a) Each Member's interest in the LLC shall be expressed as a percentage equal to the ratio on any date of such Member's Capital Account on such date to the aggregate Capital Accounts of all Members on such date, such Capital Accounts to be determined after giving effect to all contributions of property or money, distributions and allocations for all periods ending on or prior to such date (as to any Member, its "Percentage Interest"). As of the date hereof, the initial Percentage Interest of HLS shall be fifty percent (50%) and the initial Percentage Interest of WTH shall be fifty percent (50%).

(b) The LLC's profits and losses shall be allocated among the Members in accordance with the Percentage Interests of the Members.

8. Distributions. Distributions of cash or other assets of the LLC shall be made at such times and in such amounts as the Members acting unanimously may determine. Except as set forth in Section 12 hereof, distributions shall be made to the Members pro rata in accordance with respective Percentage Interests.

9. Tax Matters. It is the intention of the Members that the LLC shall be taxed as a "partnership" for federal and, where applicable, state, local and foreign income tax purposes.

10. Management.

(a) The LLC shall be managed by the Members, and the Members shall have all powers and rights necessary, appropriate or advisable to effectuate and carry out the purposes and business of the LLC. The Members may appoint, employ or otherwise contract with any persons or entities for the transaction of the business of the LLC or the performance of services for or on behalf of the LLC, and the Members may delegate to any such person (who may be designated an officer of the LLC) or entity such authority to act on behalf of the LLC as the Members may from time to time deem appropriate.

(b) The duties and powers of the Members must be taken by both Members jointly, including the execution and/or delivery of any instrument, certificate, filing or document on behalf of the LLC, or the adoption of authorizing resolutions with respect to any matter.

(c) The Members acknowledge and agree that the initial activity of the Company shall be to file for and obtain all necessary regulatory approvals to build the New Rehabilitation Hospital, including obtaining certificate of need ("CON") approval. Any decisions to be made by the Company in connection with any regulatory approval, including the CON, shall be made jointly by the Members.

11. Assignments. A Member may assign all or any part of its limited liability company interest only with the consent of all other Members. A transferee of an LLC interest can only become a substituted Member with the consent of all other Members.

12. Dissolution. The LLC shall dissolve, and its affairs shall be wound up, upon the earliest to occur of (a) the unanimous decision of the Members, (b) an event of dissolution of the LLC under the Act.

13. Distributions upon Dissolution. Upon the occurrence of an event set forth in Section 12 hereof, the Members shall be entitled to receive, after paying or making reasonable provision for all of the LLC's creditors to the extent required by the Act, their respective positive Capital Account balances until such balances, if any, are reduced to zero and then the balance shall be distributed to each such Member in accordance with their respective Percentage Interests.

14. Withdrawal. Any Member may withdraw from the LLC only upon the consent of all other Members. Upon any such permitted withdrawal, the withdrawing Member shall receive the fair value of his limited liability company interests, determined as of the date of he ceases to be a Member.

15. Limited Liability. The Members shall have no liability for the obligations of the LLC except to the extent provided in the Act.

16. Agreement to Amend and Restate; Amendment. The Members acknowledge and agree that this Agreement shall be amended and restated upon the granting of the CON. This Agreement may be amended only in a writing signed by all of the Members.

17. Governing Law. THIS AGREEMENT SHALL BE GOVERNED BY AND CONSTRUED UNDER THE LAWS OF THE STATE OF DELAWARE, EXCLUDING ANY CONFLICTS OF LAWS RULE OR PRINCIPLE THAT MIGHT REFER THE GOVERNANCE OR CONSTRUCTION OF THIS AGREEMENT TO THE LAW OF ANOTHER JURISDICTION.

18. Severability. Except as otherwise provided in this Agreement, every term and provision of this Agreement is intended to be severable, and if any term or provision of this Agreement is illegal or invalid for any reason whatsoever, such illegality or invalidity shall not affect the legality or validity of the remainder of this Agreement. The preceding sentence shall be of no force or effect if the consequence of enforcing the remainder of this Agreement without such illegal or invalid term or provision would be to cause any party to lose the benefit of its economic bargain.

19. Notices. Any notice, payment, demand or communication required or permitted to be given by any provision of this Agreement shall be in writing or by facsimile and shall be deemed to have been delivered, given and received for all purposes (a) if delivered personally to the person or to an officer of the person to whom the same is directed, or (b) when the sane is actually received, if sent either by courier or delivery service or registered or certified mail, postage and charges prepaid, or by facsimile, if such facsimile is followed by a hard copy of the facsimiled communication sent by registered or certified mail, postage and charges prepaid, addressed to the recipient party at the address set forth for such party above.

[Signature Page Follows]

IN WITNESS WHEREOF, the undersigned have duly executed this Agreement of as of the Effective Date.

HEALTHSOUTH WEST TENNESSEE HOLDING, LLC:

By: _____
Name: JOHN P. WHITTINGTON
Title: Vice President and Secretary

Jackson Madison County General Hospital District

By: _____
Name: _____
Title: _____

By: _____
Name: _____
Title: _____

IN WITNESS WHEREOF, the undersigned have duly executed this Agreement of as of the Effective Date.

HEALTHSOUTH WEST TENNESSEE HOLDING, LLC:

By: _____
Name: _____
Title: _____

Jackson Madison County General Hospital District

By: Jeffrey D. Blankenship
Name: Jeff Blankenship
Title: CFO

By: Bobby Arnold
Name: Bobby Arnold
Title: President/CEO

EXHIBIT A

Members; Initial Capital Contributions

Name and Address	Initial Capital Contribution
HealthSouth West Tennessee Holding, LLC	$1,000.00
Jackson Madison County General Hospital District	$1,000.00

Attachment A.5.
Management Agreement

MANAGEMENT AGREEMENT

THIS MANAGEMENT AGREEMENT (this "Agreement") made and entered into as of the ___ day of _____, 2015, to be effective as of the Effective Date (as defined in the Operating Agreement), by and between HealthSouth Corporation, a Delaware corporation (the "Manager"), and West Tennessee Rehabilitation Hospital, LLC (the "Owner"), a Delaware limited liability company which owns and operates a rehabilitation hospital located in Jackson, Tennessee (the "Hospital").

I. GENERAL

1. Owner's Operating Agreement; Capitalized Terms. The Owner is subject to that certain Amended and Restated Limited Liability Company Agreement effective as of the Effective Date (as the same may be amended and/or restated from time to time, the "Operating Agreement"). Capitalized terms not otherwise defined herein shall have the meaning assigned to them in the Operating Agreement.

2. Services. The Owner hereby retains the Manager for the purpose of rendering management, administration and purchasing services and support, and all other management support needed for operation, and in the best interest of the Hospital on the basis hereafter set forth, subject to the policies established by the Owner, which policies shall be consistent with applicable state and federal law. The Manager shall perform all services described in Articles II, III and IV hereof for the account of and as agent of the Owner.

3. Use of Name. The Manager hereby authorizes the Owner to use, and Owner agrees that it will use, the name "HealthSouth" in the name of the Hospital and to state in any advertising/promotional or other material that HealthSouth Corporation is an affiliate of, and acts as manager of, the Hospital.

4. Attorney-in-Fact. The Owner hereby appoints the Manager its attorney-in-fact with full power on its behalf and in its name, or in the name of the Hospital, (A) to prosecute or defend any litigation or proceeding before any governmental agency arising out of the operation of the Hospital, and (B) to enter into contracts relating to the affairs of the Hospital.

5. Assignment. Except in the event of the merger or consolidation of the Manager, or the sale by the Manager of substantially all of its assets, the Manager shall not assign this Agreement, other than to a subsidiary corporation or other entity controlled by or under common control with the Manager, without the written consent of the Owner, which consent shall not be unreasonably withheld. The Owner shall not assign this Agreement without the prior written consent of the Manager.

6. Term. The term of this Agreement shall commence as of the Effective Date and shall continue in full force and effect for a term of fifteen (15) years, automatically renewing with terms of five (5) years each unless the Manager provides notice of nonrenewal no less than ninety (90) days prior to the beginning of the renewal term.

7. Termination. Notwithstanding the provisions of the foregoing paragraph, and in addition to any other termination rights set forth herein, the parties shall have the right to terminate this Agreement as follows:

A. Termination by the Manager.

(i) Owner's Default Under this Agreement. Upon 90 days' prior written notice, the Manager shall have the right to terminate this Agreement in the event that the Owner fails to make any payments due to be paid to the Manager hereunder, other than due to a good-faith dispute, or fails to comply with any other terms of this Agreement applicable to the Owner. Such notice shall describe in detail the basis upon which the Manager believes such termination is justified. Upon receipt of such notice, the Owner shall have five (5) days during which to cure alleged payment defaults and 90 days during which to attempt to cure any other alleged default under this Agreement, and upon such cure being effected, the Manager's rights to terminate shall cease and this Agreement will continue in full force and effect. Furthermore, if the Owner has diligently attempted to effect such a cure within such 90-day period but cannot complete such cure because of the failure of a third party (such as a governmental agency) to act within such period, then the Owner shall have a reasonable time beyond such 90-day period to complete its cure of the alleged basis for the Manager's election to terminate.

(ii) In Connection with Termination of Related Agreements. The Manager shall have the right to terminate this Agreement if an affiliate of HealthSouth is no longer a member of Owner.

(iii) Manager's Right to Resign. The Manager shall have the right to resign at any time upon six (6) months prior written notice to the Owner.

B. Termination by the Owner. Upon 90 days' prior written notice, the Owner shall have the right to terminate this Agreement upon breach of this Agreement by the Manager. Such notice shall describe in detail the basis upon which the Owner believes such termination is justified. Upon receipt of such notice, the Manager shall have 90 days during which to attempt to cure any alleged default under this Agreement, and upon such cure being effected, the Owner's rights to terminate shall cease and this Agreement will continue in full force and effect. Furthermore, if the Manager has diligently attempted to effect such a cure within such 90 day period but cannot complete such cure because of the failure of a third party (such as a governmental agency) to act within such period, then the Manager shall have a reasonable time beyond such 90-day period to complete its cure of the alleged basis for the Owner's election to terminate.

II. MANAGEMENT SERVICES

1. Management Services. Subject to the provisions of Article I and the other terms and conditions of this Agreement, and the Operating Agreement, the Manager will render all services, direction, advice, supervision and assistance in the operation of the Hospital, as necessary, including, but not in any way limited to, the following:

A. Maintaining the accreditation of the Hospital with the proper agencies and insurance companies;

B. Purchasing and maintaining commercially reasonable insurance, such as property and casualty, and directors, managers and officers of the Owner, professional and other necessary insurance coverage for the Hospital; provided however, that the physicians practicing at the Hospital shall obtain their own professional liability insurance;

C. Employing, supervising, directing, leasing and discharging on behalf of the Owner, all non-physician personnel performing services at the Hospital, including the administrator of the Hospital, as needed in its sole discretion;

D. Establishing staffing schedules, wage structures and personnel policies for all personnel;

E. Negotiating fee payment methods, including Medicare reimbursement, with the appropriate third party payors and state and federal agencies;

F. Determining and setting patient charges for services provided by the Hospital;

G. Providing policies and operating procedures to all departments;

H. Providing standard formats for all charts, invoices and other forms used in the operation of the Hospital;

I. Providing for the purchase or lease by the Owner of all supplies and equipment used in the operation of the Hospital;

J. Directing the day-to-day operations of the Hospital to ensure the operations are conducted in a business-like manner;

K. Developing an ongoing advertising and promotion program;

L. Negotiating, preparing and executing on behalf of the Owner all contracts in the ordinary course of business including, without limitation, medical direction, program direction, staffing, leasing, for dietary, laboratory, radiology, emergency consultation services, and other ancillary service contracts as appropriate; and

M. Performing all management and non-medical oversight responsibilities for the Owner.

III. ACCOUNTING AND BOOKKEEPING SERVICES

1. Accounts, Books and Records. The Manager shall be responsible for establishing, reviewing, directing, supervising, and administering accounting procedures and controls and systems for the development, preparation, and safekeeping of the records and books of account relating to the business and financial affairs of the Hospital, all subject to the Owner's review. The Manager shall be responsible for managing such accounts, books, financial and statistical records, reporting materials and procedures in accordance with customary industry standards and practices, and applicable federal and state laws, rules, regulations and general instructions including the following:

A. Sweeping cash receipts received by the Company from the operation of the Hospital into an omnibus account and making timely disbursement of such funds for the operating expenses of the Hospital in accordance with the cash management provisions as more particularly described on Schedule 1 attached hereto and incorporated by reference;

B. Maintaining the books of account, including all journals and ledgers, check register and payroll records;

C. Processing vendor's invoices and other accounts payable;

D. Preparing payroll checks from the time sheet summaries prepared under the Manager's supervision;

E. Supervising the preparation of the Owner's tax returns (fees paid to independent accountants will be responsibility of the Owner);

F. Preparing monthly bank reconciliations;

G. Preparing and distributing to the Owner and its members monthly profit and loss statements; and

H. Preparing the annual operating budget, the annual capital budget and the annual strategic plan of the Owner each fiscal year.

2. Right to Review. Upon request, the Owner shall have the right at the expense of the requesting party to review and audit the accounts, books and records of the Hospital.

IV. BILLING AND COLLECTION SERVICES

The Manager will provide billing and collection services to the Owner and shall conduct such services in compliance with all applicable laws, regulations and requirements. Such services shall be billed using the Owner's provider numbers. Such services shall include without limitation:

A. Posting all patient and other charges, including necessary analysis and corrections;

B. Processing, submitting and revising, as necessary, all claims and monitoring the status of claims;

C. Processing of all payments, credits and other adjustments to patient accounts;

D. Establishing patient insurance billing procedures;

E. Preparing for and assisting in Medicare and Medical Assistance audits; and

F. Establishing adequate receivable, credit and collection policies and procedures.

V. STANDARD OF CARE

1. Standard of Performance. In the performance of its services, the Manager shall exercise and use commercially reasonable efforts in managing and operating the Hospital. Without limiting the foregoing, the Manager shall be required to utilize at least the same level of care and expertise that the Manager uses in operating its own rehabilitation centers. The Manager shall at all times use commercially reasonable efforts to maintain and enhance the reputation of the Owner and the Hospital.

2. Confidentiality. The Manager will follow its policy regarding confidential information with respect to all data, patient information and business information ("Confidential Information") received through its relationship with the Owner and management of the Hospital.

VI. FEE FOR SERVICES

1. Reimbursement of Direct Expenses. Except as provided herein, the Manager shall be reimbursed for its direct expenses incurred in connection with external services obtained on behalf of the Hospital (e.g., consulting, legal, accounting services specific to the Hospital) and expenses for information systems and insurance premiums and related fees allocated to the Hospital, including without limitation, the D&O coverage for the Owner's [board members], [directors], managers and officers. The Manager shall also be reimbursed for its direct expenses incurred for employing Hospital personnel. The Manager will be reimbursed on a monthly basis for such direct expenses.

2. Management Fee. The Owner shall pay the Manager for the services rendered under Articles II, III and IV hereof a fee equal to 5% of the Net Revenue realized by the Owner from the operation of the Hospital (the "Management Fee"). All fees and expenses shall be paid monthly no later than the 15th day of the month following the month in which the fee was earned. "Net Revenue" shall mean total patient revenues and other operating revenue (including the proceeds of claims under business interruption insurance policies) minus contractual allowances, provision for bad debt, charity care, condemnation awards, proceeds of claims under casualty insurance policies, proceeds from a sale or debt refinancing, and other capital transactions outside the ordinary course of business. The parties agree and acknowledge that the Management Fee is intended to be a fair market rate. The parties further agree to adjust such Management Fee should either party determine that such Management Fee does not meet prevailing healthcare standards for fair market rates, including, without limitation, a determination by the Manager that the Management Fee does not equal or exceed the costs incurred by the Manager to provide the management services described herein (excluding direct expenses and the cost of employing Hospital personnel).

3. No Referrals. The Manager and the Owner acknowledge and agree that the services and compensation provided hereunder do not require, are not payment for, and are not in any way contingent upon or related to the referral, admission, or any other arrangement for the Manager, the Owner or any member of the Owner to make referrals to, be in a position to make or influence referrals to, or otherwise generate business for any other such party.

VII. INDEPENDENT CONTRACTOR RELATIONSHIP

1. Independent Contractor. The Manager and the Owner affirmatively state that by virtue of entering into this Agreement, the Manager is an independent contractor of the Owner, and nothing in this Agreement shall be deemed to create any membership, joint venture or other relationship (other than independent contractors) between the Owner and the Manager. The Owner shall not be liable or responsible for vacation pay, sick leave, retirement benefits, social security, workers' compensation, disability or employment insurance benefits, state or federal withholding taxes, or any other taxes, benefits or payments for the Manager or any of its employees, contractors, representatives or subcontractors, except for the reimbursement owed to the Manager by the Owner as set forth herein. The Manager acknowledges that it is responsible for payment of all such payments and taxes and agrees to furnish proof of such payments to the Owner upon written request and further agrees to defend and indemnify the Owner against and hold the Owner harmless from any and all claims, damages, liabilities, attorneys' fees and expenses arising out of any actual or alleged failure by the Manager to pay such amounts.

2. Access to Books and Records. In the event it is determined that Section 1861(v)(1)(1) of the Social Security Act and corresponding regulations is applicable to this Agreement, it is agreed:

A. Until expiration of four (4) years after furnishing services and pursuant to this Agreement, each party shall make available upon written request of the office of the Secretary of Health and Human Services or the U.S. Comptroller General or any of their duly authorized representatives, this Agreement, books, documents, and records that are necessary to verify the nature and extent of costs incurred by the any party under this Agreement; and

B. If any party carries out any of the duties of this Agreement through a subcontract, with a value or cost of Ten Thousand Dollars ($10,000) or more over a twelve (12) month period (including contracts for both goods and services in which the service component is worth $10,000 or more over a twelve month period), with a related organization, such subcontract must contain a clause to the effect that until the expiration of four (4) years after the furnishing of services pursuant to such subcontract, the related organization shall make available, upon written request of the Secretary of Health and Human Services or the U.S. Comptroller General or any of their duly authorized representatives, the subcontract, books, documents, and records that are necessary to verify the nature and extent of costs incurred by such party under the subcontract. The parties agree that any applicable attorney-client, accountant-client or other legal privilege shall not be deemed waived by virtue of this Agreement.

If either party is requested to disclose any books, documents or records relevant to this Agreement for purpose of an audit or investigation, such party shall promptly notify the other party of the nature and scope of such request and shall make available to the other party all such books, documents and records to the extent allowable by law.

VIII. OWNERSHIP OF INFORMATION; CONFIDENTIALITY.

1. Systems Ownership. The Manager retains all ownership and other rights in all systems (including program systems and scheduling systems), manuals (including business and policy manuals), computer software, materials and other information, in whatever form provided by it in the performance of its obligations hereunder, books and records, the name "HealthSouth" or other intellectual property (collectively, referred to as the "Systems") and nothing contained in this Agreement shall be construed as a transfer of such Systems or any portion thereof, either during the term of this Agreement or thereafter. Upon the termination or expiration of this Agreement, the Manager shall retain all of the Systems.

2. Systems Confidentiality. The Owner acknowledges that the Manager has invested a significant amount of its resources in developing and maintaining the Systems and that the value to the Manager of the Systems may be diminished or destroyed if the Owner discloses the Systems or any portion thereof to a third party. Accordingly, the Owner shall maintain the confidentiality of the Systems. The Owner shall not duplicate or permit the duplication of any portion of the Systems and shall not permit access to the Systems by the Owner's personnel or any third party other than on a strict "need-to-know" basis and in the ordinary course of business. The Owner shall take at least those steps that it would take to protect its own confidential information. The provisions of this Article VIII shall survive any termination or expiration of this Agreement.

3. Systems License. The Manager hereby grants to the Owner, for the term of this Agreement, and subject to the provisions of Sections VIII.1. and VIII.2., a royalty-free, paid-up, non-exclusive license to use the Systems in connection with the operation of the Hospital.

4. Access to Information. Notwithstanding anything contained herein to the contrary, the Manager agrees to furnish or to cause to be furnished to the Owner or any of its Members upon request as promptly as practicable, such information and assistance relating to the operation of the Hospital as is reasonably necessary for the filing of any tax return, declaration or report, the making of any election related to taxes, the preparation for any audit by any taxing authority, or the prosecution or defense of any claim, suit, or proceeding. The Manager shall cooperate fully as to and to the extent reasonably requested by the Owner or any of its Members, in the conduct of any audit, litigation or other proceeding to the extent relevant to the operation of the Hospital.

IX. OBLIGATION TO PROTECT PATIENT INFORMATION

The parties agree to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d and the Health Information Technology for Economic and Clinical Health Act and any current and future regulations promulgated under either act including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards as contained in 45 C.F.R. Part 162 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as the "HIPAA/HITECH Requirements." The parties agree not to use or further disclose any Protected Health Information (as defined in 45 C.F.R. § 164.501) or Individually Identifiable Health Information (as defined in 42 C.F.R. § 1320d), other than as permitted by the HIPAA/HITECH Requirements, the terms of this Agreement, and the attached business associate addendum. The parties will make their internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the Federal Privacy Regulations. This Section shall survive termination or expiration of this Agreement.

X. NOTICES

All notices, demands, requests and other communications or documents required or permitted to be provided under this Agreement shall duly be in writing and shall be given to the applicable party at its address set forth below or such other address as the party may later specify for that purpose by notice to the other party:

If to the Manager: HealthSouth Corporation
3660 Grandview Parkway, Suite 200
Birmingham, Alabama 35243
Attention: Executive Vice President, Operations

with copy to: Legal Services Department
HealthSouth Corporation
3660 Grandview Parkway, Suite 200
Birmingham, Alabama 35243
Attention: General Counsel

If to the Owner: West Tennessee Rehabilitation Hospital, LLC
c/o HealthSouth Corporation
3660 Grandview Parkway, Suite 200
Birmingham, Alabama 35243
Attention: Executive Vice President, Operations

with copy to: West Tennessee Healthcare
620 Skyline Drive
Jackson, Tennessee 38301
Attention: General Counsel

Each notice shall, for all purposes, be deemed given and received, (i) if by hand, when delivered; (ii) if given by nationally recognized and reputable overnight delivery service, the business day on which the notice is actually received by the party; or (iii) if given by certified mail, return receipt requested, postage prepaid, the business day on which the notice is actually received by the party.

XI. INDEMNIFICATION

1. Manager's Indemnification Obligations. The Manager agrees to indemnify and hold the Owner harmless for any and all claims, demands, actions, charges, liabilities and damages, including reasonable attorneys' fees and costs of defense of any actions ("Claims"), brought or asserted by any third party and arising from or relating to the operations of the Hospital and resulting from the willful misconduct, recklessness or gross negligence of the Manager.

2. Owner's Indemnification Obligations. The Owner agrees to indemnify and hold the Manager harmless for any and all Claims, brought or asserted by any third party and arising from or relating to the operations of the Hospital except to the extent of the Manager's indemnification obligations set forth in Section XI.1. above.

XII. MISCELLANEOUS

1. Article headings are for convenience of reference only and shall not be used to construe the meaning of any provision of this Agreement.

2. This Agreement may be executed in any number of counterparts, each of which shall be an original and all of which shall together constitute one agreement. Facsimile or electronically submitted signatures on this Agreement shall be deemed to be original signatures for all purposes.

3. Should any part of this Agreement be invalid or unenforceable, such invalidity or unenforceability shall not affect the validity and enforceability of the remaining portions.

4. Each individual signing this Agreement warrants that such execution has been duly authorized by the party for which it is signing. The execution and performance of this Agreement by each party has been duly authorized by all applicable laws and regulations and all necessary corporate action, and this Agreement constitutes the valid and enforceable obligation of each party in accordance with its terms.

5. This Agreement shall be construed in accordance with the laws of the State of Delaware.

6. This Agreement may not be modified except in writing executed by the party to be charged.

7. This Agreement, together with the Operating Agreement and all other agreements executed in connection herewith or therewith, constitutes the entire agreement of the parties hereto and supersedes all prior agreements and representations with respect to the subject matter hereof.

[Signature Page Follows]

[Signature Page to Management Agreement]

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

MANAGER:
HEALTHSOUTH CORPORATION

By: _____
Name: _____
Title: _____

OWNER:
West Tennessee Rehabilitation Hospital, LLC

By: HealthSouth Jackson Holdings, Its Member

By: _____
Name: _____
Its: _____

By: Jackson Madison County General Hospital District dba West Tennessee Healthcare, its member

By: _____

Name: James Ross
Title: Chief Operating Officer

By: _____

Name: Bobby Arnold
Title: President and Chief Executive Officer

Schedule 1

Cash Management

I. Balances Available to the Owner. Each Business Day (as defined below) cash receipts received by the Owner will be swept from the Owner's bank account ("Account No. 1") into an omnibus Manager account in such banks, savings associations and other financial institutions as HealthSouth, in its sole discretion, determines is reasonable and necessary ("Account No. 2") (collectively, the "Accounts"). In accordance with the terms of this Agreement, HealthSouth will pay on behalf of the Owner accounts payable and any Owner invoices, including any amounts payable by the Owner to HealthSouth. If necessary, the Owner will execute a Power of Attorney in form and substance acceptable to the parties hereto in connection with the rights and powers granted to HealthSouth pursuant hereto. Funds swept into Account No. 2 in accordance with the foregoing will be recorded on the financial records of the Owner as of the day the funds are received by HealthSouth as an intercompany amount due from HealthSouth to the Owner ("Intercompany Due From"). As expenses or expenditures are incurred by HealthSouth on behalf of the Owner, such amounts will be recorded on the financial records of the Owner as of the month-end for the month during which such expenses or expenditures are paid as an intercompany amount due to HealthSouth from the Owner ("Intercompany Due To"). As of the last calendar day of each month (the "Calculation Date"), the net of the Intercompany Due To and Intercompany Due From will equal the total cash balance applicable to the Owner (the "Cash Balance"). If the sum of the Intercompany Due From entries exceeds the sum of the Intercompany Due To entries on the Owner's balance sheet as of the Calculation Date ("Positive Cash Balance"), then the Owner will be credited on its general ledger with interest in accordance with paragraph II.A. below. If the sum of the Intercompany Due To entries exceeds the sum of the Intercompany Due From entries on the Owner's balance sheet as of the Calculation Date ("Negative Cash Balance"), then such Negative Cash Balance will be treated as a loan to the Owner, and the Owner will be charged interest in accordance with paragraph II.B. below. For purposes of this Agreement, "Business Day" shall mean a day other than Saturday, Sunday or any day on which the principal commercial banks located in the State of New York are authorized or obligated to close under the laws of such state.

II. Interest Charges and Credits. An interest charge or credit, as applicable, will be applied to the Cash Balance (calculated in accordance with paragraph I above) and will be recorded on the Owner's financial records during the month following the Calculation Date, as follows:

A. Positive Cash Balance. If the Owner has a Positive Cash Balance as of the Calculation Date, then the Owner will be credited on its general ledger with interest during the month following the Calculation Date (the "Accounting Period"). The interest credited to the Owner during the Accounting Period will equal the Positive Cash Balance as of the Calculation Date multiplied by the blended rate of interest earned by HealthSouth on its cash portfolio during the previous month, further multiplied by a fraction, the numerator of which is equal to the number of days in the Borrowing Period and the denominator of which is the actual number of days in the current year.

B. Negative Cash Balance. If the Owner has a Negative Cash Balance as of the Calculation Date, then such Negative Cash Balance will be treated as a loan from HealthSouth to the Owner from the first calendar day through the last calendar day of the month following the Calculation Date (the "Borrowing Period"). The interest charged to the Owner during the Borrowing Period will equal the Negative Cash Balance as of the Calculation Date (i) multiplied by an interest rate equivalent to the sum of (a) the prime rate as published by Bloomberg (the "Index Rate") as of the Calculation Date (or if the Calculation Date is not a Business Day, then the first Business Day

prior to the Calculation Date), plus (b) one hundred (100) basis points (the "Interest Spread"), (ii) further multiplied by a fraction, the numerator of which is equal to the number of days in the Borrowing Period and the denominator of which is the actual number of days in the current year. The Index Rate and the Interest Spread used in the foregoing calculation will be subject to an annual review to arrive at an interest charge reflective of commercially reasonable rates. In the event the Owner has a Negative Cash Balance for six (6) consecutive months, HealthSouth may require the Owner to obtain a working capital loan from HealthSouth or a third party lending institution mutually agreeable to the members. In the event HealthSouth opts to make such loan to the Owner, the loan shall be evidenced by a promissory note issued to HealthSouth, as well as a security agreement in favor of HealthSouth granting a security interest in the Owner's assets, including, without limitation, its accounts receivable and any unbilled receivables to the extent permitted by applicable law. HealthSouth may require all members (or an affiliate of a member) of the Owner to guarantee the Owner's obligations under any such loan as a condition of financing, provided that the amount guaranteed by each member (or its affiliates) will be in proportion to the member's ownership percentage in the Owner.

BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (this "Addendum") is agreed upon by the Covered Entity and the Business Associate described herein and is made a part of and incorporated by the Underlying Agreement described herein.

R E C I T A L S

WHEREAS, HealthSouth Corporation ("Business Associate") and West Tennessee Rehabilitation Hospital, LLC are parties to the agreement to which this Business Associate Addendum is made a part (the "Underlying Agreement");

WHEREAS, pursuant to the Underlying Agreement, the Business Associate performs, or assists in the performance of, functions or activities that may involve the use or disclosure of Protected Health Information ("PHI") for the Covered Entity (the "Services"); and

WHEREAS, pursuant to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (Parts 160-164, Title 45, Code of Federal Regulations) ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Pub. L. No. 111-5 § 13402(h) and their implementing regulations (HIPAA and HITECH and their implementing regulations are collectively referred to herein as "HIPAA"), Covered Entity is required to enter into this Addendum with Business Associate.

NOW THEREFORE, in consideration of the foregoing recitals and the mutual covenants contained herein, the Covered Entity and the Business Associate (individually, a "Party", and collectively, the "Parties"), intending to be legally bound, agree as follows:

Section 1. Definitions

1.1 "Notice or Notify" means a written communication delivered personally to the required addressee or sent by United States Postal Service, first-class postage prepaid, certified or registered mail, return receipt requested, addressed to the required addressee at the address as it appears in the Underlying Agreement. Copies shall be as effective as the original for the purpose of giving notice. Any such notice shall be deemed effective on the date it was first received or five (5) days after it was properly addressed and deposited with the United States Postal Service, whichever occurs first.

1.2 "Person" shall mean a natural person, corporation, partnership, trust, association, limited liability company, or other legal entity.

1.3 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, Subparts A and E, as may be amended, modified or superseded, from time to time.

1.4 "Security Rule" shall mean the Standards for Security of Individually Identifiable Electronic Health Information at 45 C.F.R. Parts 160 and 164, Subparts A, C and E, as may be amended, modified or superseded, from time to time.

1.5 Terms used but not otherwise defined in this Addendum shall have the same meaning as those terms in HIPAA.

Section 2. Obligations of Business Associate

2.1 Permitted Uses and Disclosures. Except as otherwise limited by this Addendum, Business Associate may Use or Disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Underlying Agreement, provided that such use or disclosure would not violate HIPAA if made by Covered Entity, or as required or permitted by applicable law, rule, regulation, or regulatory agency or by any accrediting or credentialing organization to whom a Party is required to disclose such PHI. Notwithstanding the forgoing, Business Associate may: (i) use or disclose PHI, if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate; (ii) if applicable, in order to provide data aggregation services; and (iii) disclose PHI, if necessary: (a) if the disclosure is Required by Law, or (b) Business Associate obtains reasonable assurances from the Person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the Person, and the Person notifies Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached; or

2.2 Prohibited Uses and Disclosures. Business Associate shall not Use or Disclose PHI in a manner that would violate the terms of this Addendum or HIPAA, if such Use or Disclosure would constitute a violation of HIPAA if done by Covered Entity, it being the intent of the Parties that the requirements of HIPAA that are applicable with respect to Covered Entity shall also be applicable to Business Associate in all respects and shall be incorporated by reference into this Addendum.

2.3 Marketing Communication. Business Associate shall not Use or Disclose PHI for use in a Marketing Communication or otherwise engage in a Marketing Communication unless Business Associate has received prior written authorization from Covered Entity.

2.4 Prohibition on the Sale of Electronic Health Records. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI received from Covered Entity without the prior written authorization of Covered Entity.

2.5 Business Associate Agents and Subcontractors. Business Associate shall ensure that its agents, including subcontractors, to whom it provides PHI, created by or received from Covered Entity, agree in writing to the same restrictions and conditions that apply to Business Associate pursuant to this Addendum with respect to PHI.

2.6 Appropriate Safeguards. Business Associate and its agents or subcontractors shall implement the appropriate safeguards necessary to prevent the improper Use or Disclosure of PHI by complying with all applicable administrative, physical, and technical safeguards set forth in the Security Rule. Business Associate shall Notify Covered Entity of any Security Incident within five (5) business days of the date Business Associate becomes aware of such Security Incident.

2.7 Government Access to Records. Business Associate shall make its internal practices, books, and records relating to the Use and Disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary for purposes of determining compliance with HIPAA. Business Associate shall provide Covered

Entity with a copy of any PHI that Business Associate provides to the Secretary concurrently with providing such PHI to the Secretary.

2.8 Reporting of Improper Use or Disclosure. Business Associate shall Notify Covered Entity of any Use or Disclosure of PHI that may constitute a Breach, or suspected Breach, of Unsecured PHI within five (5) business days of the discovery of such Breach, or suspected Breach. Such notice shall include, at a minimum, the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been the subject of the Breach or suspected Breach, and any other information reasonably requested by Covered Entity. An actual or suspected Breach shall be treated as discovered by Business Associate as of the first day on which such Breach is known to the Business Associate or its Workforce or, by exercising reasonable diligence, should have been known to Business Associate or its Workforce. Business Associate's notification to Covered Entity, to the extent possible, shall include the identity of each Individual whose Unsecured PHI has been, or is reasonably believed to have been, Breached and be in substantially the same form as ATTACHMENT 2.8 hereto. Business Associate further agrees to fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of HIPAA.

2.9 Mitigation. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate as the result of an improper Use or Disclosure of PHI by Business Associate in violation of the requirements of this Addendum or HIPAA. Failure to mitigate any such harmful effect shall constitute a material breach of this Addendum and the Underlying Agreement.

2.10 Breach Practice or Pattern of Activity of Subcontractor. To the extent required by HIPAA, if Business Associate knows of a practice or pattern of activity of a subcontractor that constitutes a material breach or violation of the subcontractor's obligations to appropriately safeguard Covered Entity's PHI, then Business Associate shall provide written notice to such subcontractor within forty-eight (48) hours of discovery the subcontractor's practice or pattern of activity and attempt to resolve the problem and take reasonable steps to mitigate the effects of the violation, as applicable.

2.11 Availability of PHI. To the extent that PHI is part of a Designated Record Set, and that such Designated Record Set (or a portion thereof) is maintained by Business Associate, Business Associate shall within ten (10) business days after a written request from Covered Entity (i) provide access to the PHI by Covered Entity or an Individual, in a manner designated by the Covered Entity or as otherwise Required by Law; and/or (ii) make amendments to such PHI as directed or agreed to by Covered Entity in accordance with the requirements of HIPAA.

2.12 Accounting of Disclosures. Within five (5) days of receipt or a request from Covered Entity, Business Associate shall make available to Covered Entity the information required to provide an accounting as would be required of Covered Entity in response to a request by an Individual for an accounting of Disclosures of PHI in accordance with HIPAA. Furthermore, Business Associate agrees to implement a process that allows for an accounting to be collected and maintained by Business Associate and its agents or subcontractors for at least six (6) years prior to the request (except for disclosures occurring prior to the Effective Date). At a minimum, such accounting information shall include, without limitation: (i) the date of disclosure of PHI; (ii) the name of the entity or Person who received PHI and, if known, the address of the entity or Person; (iii) a brief description of PHI disclosed; and (iv) a brief statement of purpose of the Disclosure that reasonably informs the Individual of the basis for the Disclosure, or a copy of the

written request for Disclosure. If a request for an accounting is delivered directly to Business Associate, Business Associate shall as soon as possible, but no later than five (5) business days after receipt of the request, forward the request to Covered Entity.

2.13 Cooperation. Business Associate agrees to cooperate with Covered Entity in the case of a Breach of Unsecured PHI to the extent such Breach was caused, directly or indirectly, by the action or inaction of Business Associate. For purposes of this Section 2.13, Business Associate's cooperation shall include, without limitation, assisting Covered Entity in the following: (i) determining how the Breach occurred, including the date of the Breach and the date of the discovery of the Breach, if known; (ii) determining the Individuals affected by the Breach; (iii) determining the types of Unsecured PHI involved in the Breach (e.g., full name, Social Security number, date of birth, home address, account number, or disability code); (iv) determining what steps Individuals should take to protect themselves from potential harm resulting from the Breach; (v) investigating how the Breach occurred, methods to mitigate losses and protect against further losses; and (vi) developing contact procedures for individuals who wish to obtain additional information from Business Associate and/or Covered Entity about the Breach, which shall include a toll-free number, an email address, website, or postal address.

2.14 Minimum Necessary; Use and Disclosure Requirement. With respect to any Use, Disclosure, or request of PHI permitted under the terms of this Addendum and/or HIPAA, Business Associate shall make reasonable efforts to limit the Use or Disclosure of PHI to the Minimum Necessary in order to accomplish the intended purpose of the Use, Disclosure, or request. Furthermore, Business Associate will restrict access to PHI only to those employees of Business Associate or other Workforce members who are actively and directly participating in providing goods and/or services under the Underlying Agreement of the parties and who need to know such information in order to fulfill such responsibilities.

Section 3. Covered Entity Obligations

3.1 Notice of Privacy Practices. Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with HIPAA, as well as any subsequent changes to the notice of privacy practices.

3.2 Changes in Access by Individual. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an individual to use or disclose PHI, if such changes affect Business Associate's permitted or required Uses and Disclosures.

3.3 Restrictions on Use and Disclosure of PHI. Covered Entity shall Notify Business Associate of any restriction to the Use or Disclosure of PHI that Covered Entity has agreed to in accordance with HIPAA.

Section 4. Termination.

4.1 Term. The term of this Addendum shall commence on the Effective Date of the Underlying Agreement and shall terminate when Business Associate ceases to perform the Services or the Underlying Agreement terminates; provided, however, that certain obligations shall survive termination of this Addendum as set forth in Section 4.2 and Section 5.

4.2 Termination for Cause. Covered Entity may immediately terminate the Underlying Agreement if Business Associate materially breaches any provision of this Addendum. At its sole and absolute

discretion, Covered Entity may permit Business Associate to cure such material breach to Covered Entity's satisfaction within thirty (30) days after receipt of written notice from Covered Entity.

4.3 Effect of Termination. Upon termination of the Underlying Agreement for any reason, Business Associate shall return or destroy all PHI (regardless of form or medium), including all copies thereof and any data compilations derived from PHI that identifies any Individual who is the subject of the PHI returned or destroyed. The obligation to return or destroy all PHI shall also apply to PHI that is in the possession of agents or subcontractors of Business Associate. If, in the reasonable judgment of the Business Associate, the return or destruction of PHI is not feasible, Business Associate shall provide Covered Entity written notification of the conditions that make return or destruction not feasible, and Business Associate shall continue to extend the protections of this Addendum to such information and limit further uses or disclosures of such PHI to those purposes that make the return or destruction of such PHI not feasible, for as long as Business Associate maintains such PHI. If Business Associate elects to destroy the PHI, Business Associate shall Notify Covered Entity in writing that such PHI has been destroyed or otherwise unreadable, undecipherable, or unusable in accordance with HIPAA.

Section 5. Indemnification.

Business Associate shall indemnify and hold Covered Entity, and each of its respective employees, partners, members, independent contractors, agents and representatives (collectively the "Indemnified Persons"), harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other reasonable expenses, of any kind or nature whatsoever, including, without limitation, attorneys' fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any Breach, including without limitation, (a) expenses the Indemnified Persons directly or indirectly incur in notifying affected Individuals of a Breach caused by Business Associate or its Workforce and (b) any penalties, sanctions, assessments, or charges incurred by the Indemnified Persons resulting from Business Associate's failure to comply with the terms and conditions of this Addendum. Covered Entity shall tender to Business Associate the defense of any claim(s) for which indemnification is sought, provided that Covered Entity shall have the right at its own expense to participate in the defense of such claim(s) and neither party shall take any final action with respect to a any claim without the prior written consent of the other party. Failure of Covered entity to promptly tender defense to Business Associate shall relieve Business Associate of its indemnity obligations under this paragraph.

Section 6. Miscellaneous.

6.1 Effect of Underlying Agreement.

a. To the extent that any provisions of this Addendum conflict with provisions contained in the Underlying Agreement, the provisions of this Addendum shall control.

b. Any vagueness or ambiguity in this Addendum shall be resolved in favor of a meaning that permits the Parties to comply with HIPAA.

6.2 Amendment to Comply with Law. The Parties acknowledge that it may be necessary to amend this Addendum in order to comply with amendments or modifications to HIPAA, including but not limited to statutory or regulatory modifications or interpretations by a regulatory agency or

court of competent jurisdiction. No later than sixty (60) days after the effective date of any such modifications, the Parties agree to use good faith efforts to develop and execute any amendments to this Addendum as may be required for compliance with HIPAA. If the Parties cannot in good faith agree upon any such amendment within such timeframe (or other timeframe acceptable to the Parties), either Party may terminate the Underlying Agreement without liability, subject to the obligations set forth in Section 4.

6.3 Amendment. This Addendum may be amended or modified only in writing signed by the Parties. This Addendum is intended to supersede and replace any and all current Business Associate Agreements between Business Associate and Covered Entity.

6.4 Ownership of PHI. Covered Entity shall retain all rights of ownership in the PHI.

6.5 Independent Contractor. Business Associate shall be an independent contractor of Covered Entity. No joint venture or partnership, no relationship of employer and employee, master and servant or principal and agent, is created by this Agreement and neither party shall be considered an agent, servant or employee of the other party.

6.6 Injunctive Relief. Business Associate agrees that Covered Entity would suffer irreparable harm if Business Associate were to breach, or threaten to breach, any provision of this Addendum and that the Covered Entity would by reason of such breach, or threatened breach, be entitled to injunctive relief in a court of appropriate jurisdiction, without the need to post any bond, and Business Associate further consents and stipulates to the entry of such injunctive relief in such a court prohibiting Business Associate from breaching this Addendum. This Section 6.6 shall not, however, diminish the right of Covered Entity to claim and recover damages and other appropriate relief.

Attachment 2.8

Notification to Covered Entity about a Breach of Unsecured PHI

This notification is made pursuant to Section 2.8 of the Business Associate Addendum (the "Addendum") between [JV LLC] ("Covered Entity") and HealthSouth Corporation ("Business Associate").

Business Associate hereby notifies Covered Entity that there has been an actual or suspected Breach of Unsecured PHI that Business Associate has used or has had access to under the terms of the Addendum.

1. Description of Breach: _____
_____
_____
_____

2. Date of Breach (if known): _____

3. Date of the Discovery of Breach: _____

4. Number of Individuals affected by Breach: _____

5. The types of Unsecured PHI that were involved in Breach (such as the name, Social Security number, date of birth, home address, account number or disability code of the affected Individuals): _____
_____
_____
_____

6. Description of the steps Business Associate is taking to investigate Breach, mitigate losses, and to protect against any further Breaches: _____
_____
_____
_____
_____

7. Contact information for Covered Entity and Affected Individuals to ask questions or learn additional information:

   A. Name and Title: _____

   B. Address: _____
   _____

   C. Email address: _____

   D. Telephone Number: _____

Attachment A.6.

Ground Lease

70297093015-WCB

DRAFT FOR DISCUSSION PURPOSES

STATE OF TENNESSEE :
COUNTY OF MADISON :

GROUND LEASE

This **GROUND LEASE** (this "**Lease**") is made and entered into effective as of the ___ day of _____, 200__, by and between **WEST TENNESSEE HEALTHCARE, INC.**, a Tennessee nonprofit corporation and governmental instrumentality of Jackson-Madison County General Hospital District ("**Landlord**"), and **WEST TENNESSEE REHABILITATION HOSPITAL, LLC**, a Delaware limited liability company ("**Tenant**").

W I T N E S S E T H:

WHEREAS, Landlord owns that certain tract or parcel of land containing approximately _____ (___) acres located at 616 West Forest Avenue in Jackson, Tennessee, which land is more particularly described on Exhibit A attached hereto and incorporated herein by this reference (the "**Land**"); and

WHEREAS, Tenant is a joint venture between Jackson-Madison County General Hospital District and HealthSouth Corporation, and the JV will provide state of the art rehabilitation services to people of the Jackson-Madison County area; and

WHEREAS, Tenant intends to construct certain improvements on the Land (a "**Building**") and necessary parking and other infrastructure improvements ("**Other Improvements**") (the Other Improvements together with the Building, collectively the "**Improvements**"), pursuant to the terms of a Consulting Services Development Agreement; and

WHEREAS, the public will benefit from the enhanced delivery of patient care services in the form of a new rehabilitation facility.

NOW, THEREFORE, In consideration of the rent to be paid, the mutual covenants and agreements herein contained, and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

ARTICLE 1.
PREMISES

Landlord hereby demises and rents the Land unto Tenant, and Tenant hereby rents and hires from Landlord the Land, herein called the Leased Premises, together with any and all improvements located thereon and appurtenances thereto (collectively, the "**Demised Premises**"); together with the non-exclusive right of ingress and egress for pedestrian and vehicular traffic to and from the Building over all sidewalks and walkways and roadways as reflected as Ingress and Egress areas on a recorded plat in the Register's Office of Madison County, Tennessee, on Landlord's property adjacent to the Demised Premises.

The foregoing rights and easements shall be appurtenant to the Demised Premises and are hereinafter included in the definition of the Demised Premises.

ARTICLE 2.
TERM OF LEASE AND RENTAL

Unless this Lease is terminated pursuant to the provisions of Article 2A, the initial term of this Lease shall be for a period of twenty-five (25) years (the "**Initial Term**"), commencing on the date Landlord completes demolition of existing improvements on the Land and turns the Land over (in a non-pad ready condition) to Tenant (the "**Commencement Date**"), and ending on the last day of the month during which the twenty-fifth (25th) anniversary of the Commencement Date occurs (the "**Expiration Date**"). On or about the Commencement Date, Landlord and Tenant shall execute a written agreement establishing the Commencement Date.

At the end of the Initial Term, the Initial Term shall renew automatically for consecutive renewal terms of five (5) years each, unless either Landlord or Tenant provides at least six (6) months prior notice to the other in accordance with Article 23 of its intent not to renew the Lease (each a "**Renewal Term**"). The Initial Term, together with all exercised Renewal Terms, shall hereinafter be referred to as the "**Term**".

Beginning on the Commencement Date, Tenant shall pay to Landlord, annually in advance, without demand, setoff or deduction, rent for the first year of the Term of $_____ ("**Rent**"). Rent, as increased as set forth below, shall continue on each annual anniversary thereafter. Rent shall be increased on each anniversary of the Rent Commencement Date by the greater of: one-half of the annual percentage increase in the Consumer Price Index for all Urban Consumers published by the Bureau of Labor, U. S. City Average (1982 – 1984 = 100) (the "**CPI**") from the Rent Commencement Date or the immediately preceding anniversary of the Rent Commencement Date, as applicable, to the date of adjustment in Rent; or two percent (2%) per annum.

If the CPI is no longer prepared and published, then the percentage increase in Rent shall be determined by the percentage increase in any comparable index then prepared for such time period and published by an agency of the government of the United States, appropriately adjusted for changes in the manner in which such Index is prepared and/or the year upon which such Index is based.

Any Rent not paid by Tenant within fifteen (15) days following the date when due shall bear interest at the Prime Rate of Interest of Bank of America, N.A. (or its successor, if applicable) in effect on such date (the "**Prime Rate**") from the date due until paid. Additionally, if Tenant is delinquent in the payment of any Rent for more than ten (10) days following the date when due, Tenant shall pay Landlord, without demand, a late charge equal to five percent (5%) of such delinquent sum as liquidated damages to compensate Landlord for Landlord's costs, expenses and other damages which it will incur as a result of such late payment, but which are not readily quantifiable. The foregoing interest and late charges shall be in addition to all of Landlord's other rights and remedies hereunder or at law.

In addition to Rent, beginning as of the Rent Commencement Date, Tenant shall pay to Landlord such amounts as are necessary to reimburse Landlord for Tenant's Pro Rata Share of common area maintenance expenses ("**CAM Charges**"). For purposes hereof, "**Tenant's Pro Rata Share**" shall mean a percentage to be negotiated reasonably and in good faith and agreed upon by Landlord and Tenant on or before _____, 2016. On or before _____ of each year during the Term, beginning with _____, Landlord and Tenant shall negotiate reasonably, diligently, and in good faith to reach agreement upon a budget of CAM Charges for the immediately following calendar year of the Term (each, a "**CAM Budget**"). Upon reaching agreement on the CAM Budget, beginning on January 1st and continuing on the first day of each month of the immediately following calendar year, Tenant shall pay to Landlord one-twelfth (1/12th) of Tenant's Pro Rata Share of the CAM Charges identified in the CAM Budget for such year. In the event Tenant's Pro Rata Share of the actual CAM Charges for such year exceeds the payments collected by Landlord from Tenant, Tenant shall pay such excess within twenty (20) days after receipt of notice from Landlord of the amount of the excess. In the event Tenant's Pro Rata Share of the actual CAM Charges for such year is less than the payments collected by Landlord from Tenant, Landlord shall, at Tenant's option, either return the difference to Tenant or credit the difference to future payments of Tenant's Pro Rata Share of CAM Charges.

Upon request by Tenant, and at Tenant's cost and expense, noting that Landlord will not charge any fees for said request, Landlord shall furnish to Tenant such information as may be reasonably necessary for Tenant to verify the CAM Charges and shall cooperate with Tenant in verifying the CAM Charges. The calculation of the CAM Charges shall be rendered by Landlord to Tenant within one (1) month after calculation of the same by Landlord (the "**Statement of CAM Charges**").

Tenant shall have ninety (90) days after receipt of the Statement of CAM Charges to dispute the correctness or completeness thereof, after which time the Statement of CAM Charges shall be deemed to be complete and correct and conclusive and binding on Landlord and Tenant. Tenant shall not be entitled to withhold payment of CAM Charges for any reason, but payment of any CAM Charges shall not preclude Tenant from thereafter disputing the correctness or completeness of the Statement of CAM Charges. In the event Tenant shall dispute the Statement of CAM Charges, and Landlord and Tenant cannot resolve the dispute within four (4) months after Landlord renders the Statement of CAM Charges, then the matter may be submitted to the Chancery Court of Madison County, Tennessee for resolution.

The term "CAM Charges" shall include ad valorem property taxes, if any, and all normal costs of operating, maintaining and insuring those portions of the Land and the improvements thereon that are used by Tenant in common with others, including, without limitation, the driveways, parking areas, sidewalks, walkways, lighting and landscaping; provided however, "CAM Charges" shall not include the cost of any capital improvements, replacements nor reserve amounts.

ARTICLE 2A.
EARLY TERMINATION FOR DISSOLUTION OF TENANT

Notwithstanding the Term set forth in Article 2, in the event that Tenant is dissolved pursuant to its LLC Agreement by either of its Members, this Lease shall terminate upon the completion of the dissolution and distribution of the Jackson Rehab Hospital (as defined in the LLC Agreement) to West Tennessee Healthcare. Thereafter, Landlord shall pay to Tenant the unamortized amount of the cost of the Improvements pursuant to the procedures and calculations set forth in Article 18.

ARTICLE 3.
LANDLORD IMPROVEMENTS

Prior to the Commencement Date, Landlord, at its sole cost and expense, shall raze the building structures on the Land and remove the debris therefrom, and leave the Land in such condition as exists after the debris removal (i.e. not pad ready). Further, Landlord shall make available, or cause to be made available to the Demised Premises, all utilities and similar services (together "**Utilities**"), including without limitation water, sewer, gas, electricity, telephone and telecommunications. The razing of the existing structures on the Land and providing the availability of utilities shall be referred to as the "**Landlord Improvements**." Such Utilities shall be made available to the Demised Premises at or prior to the Commencement Date, or at such other time as such shall be acceptable to Tenant and shall be made available in such quantities or having such capabilities and capacities as are consistent with the intended use of the Demised Premises. No other Landlord Improvements to the Demised Premises are required as a condition of this Lease. All other improvements are the responsibility of Tenant.

ARTICLE 4.
TENANT IMPROVEMENTS AND ALTERATIONS

Tenant shall develop, construct and operate upon the Demised Premises, at its sole cost and expense, the Building and Other Improvements. The Building and Other Improvements will be constructed substantially in accordance with the Plans and Specifications prepared by _____ and more fully described in Exhibit C attached hereto (the "**Plans and Specifications**"). Tenant shall submit the Plans and Specifications for the Building and Other Improvements to a person designated by Landlord for Landlord's approval. The review and approval of Landlord will not be unreasonably withheld, conditioned nor delayed. If Landlord does not notify Tenant of any disapproval or request any changes within thirty (30) days after submission by Tenant of the Plans and Specifications, approval by Landlord shall be deemed granted. If Landlord disapproves any portion of the Plans and Specifications or requests any amendments thereto, written disapproval specifically describing the items to which objection is registered, or written request for amendments, shall be delivered to Tenant within such thirty (30) day period. It is understood and agreed that Landlord and Tenant will work together in submitting and responding to requests for approvals in a reasonable, expeditious manner.

Subject to the provisions below, construction of the Building and Other Improvements will begin not later than _____, _____ and will be completed not later than _____

(___) months after the date of commencement of construction. It is agreed that the commencement and completion dates shall be extended as a result of (a) any delays resulting from changes requested by Landlord in the Plans and Specifications for the Building and Other Improvements, and (b) the occurrence of events or circumstances not within the reasonable control of Tenant.

There shall be excluded from the computation for the period of time allowed herein for the completion of the construction of the Building and Other Improvements, any delays due to strikes, riots, acts of God, acts of war or terrorism, shortages of labor or materials, war, governmental laws, regulations or restrictions or any other causes of any kind whatsoever which render Tenant physically incapable of performing and which with the exercise of due diligence by Tenant cannot reasonably be prevented or overcome. Any event which may delay performance under the terms and provisions of this paragraph shall be herein called an "**unavoidable delay**". Tenant, in order to rely on an unavoidable delay, shall send written notice to Landlord within ten (10) business days after the occurrence of any unavoidable delay upon which it is relying to delay performance hereunder. The occurrence of an unavoidable delay shall not excuse the obligation of Tenant to construct the Building and Other Improvements as required by this Lease, and the Tenant in relying on such unavoidable delay shall be excused from performance hereunder only during such time as such unavoidable delay persists. Tenant shall exercise commercially reasonable efforts to remedy such unavoidable delay and to perform its delayed obligation with all reasonable dispatch.

After the Plans and Specifications described in Exhibit C are approved by Landlord, Tenant shall make no material structural changes or alterations in the Building and Other Improvements as may be constructed upon the Demised Premises nor material changes in the external decor of the Building or Other Improvements without the prior written consent of Landlord. Tenant may make such interior decorative and functional configurations of the Building as are consistent with the operation of a rehabilitation hospital, provided the same may be in compliance with the other terms of this Lease.

Landlord agrees that during the entire Term of this Lease, Landlord shall grant Tenant such easements as reasonably requested to permit Tenant, at Tenant's cost and expense, to relocate and/or tie into and utilize sewer lines or other Utilities which run through or across the Landlord's adjacent properties. Such easements shall include the right of reasonable ingress and egress and the right to maintain, repair or tap into, at Tenant's expense, such sewer lines or other utilities. Any utility line located in the immediate construction area of the Building may be relocated by Tenant, at its cost; provided, however, that such relocation shall be undertaken only with proper consents and approvals from the City of Jackson and all governmental and non-governmental entities having jurisdiction over such utility lines and easement areas.

All buildings (including the Building) and Other Improvements constructed on the Demised Premises shall remain upon the Demised Premises at the termination of the Lease and shall, at that time, become the property of the Landlord. Compensation for the Improvements to be paid by Landlord to Tenant shall be as provided in Article 18, Section F. No improvements shall be constructed so as to subject the Demised Premises, or permit the Demised Premises to be subjected to liens of any laborer, contractor, mechanic or materialman or to any other liens arising out of or connected with the development, construction or maintenance of any improvements, alterations or

additions to existing improvements (except for statutory liens arising in the ordinary course which are promptly discharged), unless Landlord expressly consents to such liens in writing.

Tenant shall keep all of the Demised Premises free and clear of all liens arising out of or claimed by reason of any work performed, materials furnished, or obligations incurred by or at the instance of Tenant. Upon completion of the Building and Other Improvements constructed from time to time by Tenant, Tenant shall record, or cause to be recorded, a Notice of Completion of the Building in the Madison County, Tennessee Register's Office and shall furnish promptly to Landlord final sworn Owner's and Contractor's Affidavits and final Lien Waivers covering all labor and materials included in the Building and other improvements.

Should Tenant fail either to (i) discharge fully any liens against the Building and Other Improvements; or (ii) contest such liens, and in connection with such contest insure or bond over such liens by title endorsement or bond reasonably satisfactory to Landlord (which endorsement or bond shall also cover costs of defense), within thirty (30) days following receipt of written notice from Landlord to do so, then Landlord may, at its option and without limitation of any other rights or remedies, pay the same or any part thereof, and the amount of any such payments shall be due and owing to Landlord from Tenant with interest thereon at the Prime Rate from the date incurred until paid in full. No lien of any character whatsoever created or suffered by Tenant, including without limitation the lien of any Leasehold Deed of Trust, shall in any way or to any extent attach to Landlord's fee simple ownership of the Demised Premises.

Tenant shall at all times keep the Building and Other Improvements in "Class A" condition and repair, and Tenant shall keep the Building and Other Improvements in a clean and sightly condition.

ARTICLE 5.
REMOVAL OF FIXTURES AND PERSONAL PROPERTY FURNISHED BY TENANT

Tenant shall have the right at the termination of the Lease to remove any and all personal property, medical equipment and trade fixtures which it may have stored or installed in the Building or upon the Demised Premises, provided Tenant repairs any damage to the Building or Demised Premises resulting from removal of such personal property, medical equipment or trade fixtures.

ARTICLE 6.
TITLE AND OWNERSHIP

Landlord is the fee simple owner of the Land. Landlord represents and warrants that Landlord is authorized to execute this Lease for the Term herein granted under the terms and conditions provided herein and that said Lease is enforceable against Landlord in accordance with its terms. Landlord agrees to provide an opinion of counsel acceptable to Tenant that proper action has been taken by its Board of Trustees to enter into this Lease.

ARTICLE 7.
USE OF PREMISES; QUIET ENJOYMENT

(a) **Use Of Premises.** The Tenant agrees that the Demised Premises will be used solely and exclusively as a rehabilitation hospital unless otherwise consented to in writing in advance by Landlord, in its sole and absolute discretion. Further, Tenant agrees that the Demised Premises shall be used and occupied in a careful, safe, proper, and lawful manner, and no nuisance, trade or custom, or environmental condition which is unlawful shall be permitted therein. No waste shall be committed on the Demised Premises nor damage done to the Demised Premises, ordinary wear and tear excepted. At the end of the Lease Term, regardless of how and when the Lease Term ends, Tenant will leave all Improvements it constructed on the Leased Premises, which shall become Landlord's property.

(b) **Tenant's Quiet Enjoyment.** Landlord covenants that Tenant, on the performance of the terms and conditions of this Lease, shall and may peaceably and quietly have, hold and enjoy the Demised Premises for the full term of this Lease, subject to Article XVI, Condemnation.

ARTICLE 8.
NO PARTNERSHIP OR JOINT VENTURE

Under no circumstances as a result of this Lease shall Landlord and Tenant be deemed or held to be partners or joint venturers in or concerning the Building and Other Improvements to be developed, constructed, and operated under this Lease.

ARTICLE 9.
UTILITIES

Tenant shall be responsible for contracting for utility and other services to the Demised Premises throughout the Term. Except for Landlord obligations under Article III hereof, Tenant shall pay all charges for utility services furnished to the Demised Premises during the Term. In addition, Tenant shall be responsible for contracting with reputable service contractors pursuant to customary service contracts to service, on a regular basis, the heating, ventilating, air conditioning, janitorial service, and other systems located at the Building. Tenant shall provide Landlord, upon request, true, correct and complete copies of all such service contracts.

Except to the extent caused by the negligence or willful misconduct of Landlord, its employees, contractors or agents, no interruption of services or utilities caused by repairs, replacements or alterations to any service systems, or by any other cause, shall be deemed an eviction or disturbance of Tenant's use or possession of any part of the Demised Premises nor render Landlord liable to Tenant for damages, nor otherwise affect the rights and obligations of Landlord and Tenant under this Lease.

ARTICLE 10.
PAYMENT OF TAXES OR ASSESSMENTS

Landlord represents that at the time of execution of this Lease there are no taxes due and owing on the Demised Premises; provided, however, that ad valorem property taxes on the Demised Premises shall be prorated as of the Commencement Date for the year in which the Commencement Date occurs. If at any time during the Term of this Lease any ad valorem property taxes or other assessments are made against the Demised Premises or the Building, Tenant shall be liable for payment of any and all such taxes and assessments. If Landlord receives notice of any such taxes or assessments, Landlord agrees to forward same to Tenant. Tenant will, at all times during the Term of this Lease, save harmless Landlord from all such taxes, assessments and charges against the Building and from all liens and penalties in conjunction therewith.

Nothing herein shall be construed as preventing or interfering with the contestation by Tenant, at its own expense, of any tax, assessment, charge, lien or claim of any kind in respect to the Demised Premises or the Building, and Tenant shall not be considered in default with respect to payment thereof for so long as the matter shall remain undetermined by final judgment.

ARTICLE 11.
MAINTENANCE AND SERVICES TO DEMISED PREMISES

A. Maintenance and Repairs. Tenant shall make and pay for all maintenance, replacement, alterations, and repairs, ordinary as well as extraordinary, structural as well as nonstructural, foreseen as well as unforeseen, necessary to keep the Demised Premises and all equipment and facilities located therein in a good state of repair, consistent with other medical office buildings and hospitals of similar age and character, in compliance with all governmental regulations and in a tenantable, safe condition, reasonable wear and tear excepted. Such maintenance and repair obligations shall include, without limitation, all necessary maintenance and repair to the roof, foundation, outer walls, structural portions and systems of the Demised Premises, as well as all maintenance, replacement, and repair (including sweeping, stripping, and snow and ice removal) necessary to maintain all driveways, sidewalks, street, loading, and parking areas serving the Demised Premises free of all settling, clear of standing water, and in a sightly and serviceable condition.

B. Services. Tenant shall be responsible for contracting for utility and other services to the Demised Premises throughout the Term. Tenant shall pay all charges for utility services furnished to the Demised Premises during the Term. In addition, Tenant shall be responsible for contracting with reputable service contractors and pursuant to customary service contracts to service, on a regular basis, the heating, ventilating, air conditioning, and other systems located in the Demised Premises as well as all freight and passenger elevators and janitorial services. Upon request, Tenant shall provide Landlord with true, correct, and complete copies of all such service contracts.

ARTICLE 12.
NO LEASEHOLD FINANCING

Tenant acknowledges to Landlord that there will be no leasehold financing and the Tenant's interest in this Lease will remain unencumbered.

ARTICLE 13.
ESTOPPEL CERTIFICATE

Landlord and Tenant shall each, without charge, at any time and from time to time hereafter within ten (10) days after written request of the other, certify by written instrument duly executed and acknowledged to the other, or to any other person, firm or corporation specified in such request: (a) as to whether this Lease has been supplemented or amended, and if so, the substance and manner of such supplement or amendment; (b) as to the validity and force and effect of this Lease in accordance with its terms; (c) as to the existence of any default hereunder; (d) as to the existence of any offsets, counterclaims or defenses thereto on the part of either party to this Lease; (e) as to the commencement and expiration dates of the Term of this Lease; (f) as to any other matters as may be reasonably requested.

Any such certificate may be relied upon by the party who requested it and any other person, firm or corporation to whom the same may be exhibited or delivered, and the contents of such certificate shall be binding on the party executing the same.

ARTICLE 14.
INSURANCE

Before commencement of any construction of Improvements on the Demised Premises, Tenant shall procure and maintain in force and effect until completion thereof, "All Risks" Builder's Risk Insurance, including vandalism and malicious mischief, covering the construction of the Building and Other Improvements and all material and equipment at the job site furnished under the Contract for such construction, with limits not less than the cost of the completed construction, including increased costs resulting from change orders or other increased costs of construction.

During the Term of this Lease, Tenant shall maintain in effect insurance on all structures erected from time to time on the Demised Premises, including without limitation the Building, providing one hundred percent (100%) replacement cost coverage, with an All Other Peril Deductible not to exceed $50,000.00, unless mutually agreed upon by Landlord and Tenant, for fire and such other hazards as are readily available in the marketplace and normally insured by commercial property owners.

Tenant also will carry and maintain earthquake insurance coverage in an amount equal to the lesser of: (i) the 250 year probable maximum loss, as calculated by Tenant's insurer, with respect to the Building; and (ii) coverage that is readily available to Tenant with a deductible not to exceed those commonly carried by commercial property owners.

In addition, Tenant will carry and maintain public liability insurance with respect to the Demised Premises and Building and Other Improvements to afford protection with limits for each occurrence of not less than $3,000,000.00 with respect to personal injury and death, and $1,000,000.00 with respect to property damage, with adjustment to such limits equal to or greater than adjustments in the U. S. Department of Labor Cost of Living Index. Landlord shall be named as an additional insured in all such liability insurance policies. Landlord shall be named as an additional loss payee on all policies of insurance.

Tenant shall provide Landlord with copies of all insurance policies specified herein promptly upon receipt thereof from its insurer and shall provide Landlord with such further evidence of insurance as reasonably requested from time to time. If at any time during the Term of this Lease Tenant fails to maintain in force the insurance, Landlord shall be entitled, at its option, to obtain any and all such insurance; and in such event, Landlord shall be reimbursed by Tenant for all costs and expenses associated with obtaining such insurance, upon written demand from Landlord to Tenant, including any additional costs and reasonable attorney's fees incurred by Landlord.

During the Term of this Lease, Tenant shall, at its expense, maintain reasonable general liability insurance in an amount reasonably agreed upon by Tenant and Landlord, sufficient to protect and indemnify Landlord and Tenant from any and all claims of liability resulting from the proposed development, construction and operation of the Building. Landlord shall be named as an additional insured in all such liability insurance policies.

ARTICLE 15.
INDEMNIFICATION

Tenant shall indemnify and save harmless Landlord from and against any and all claims, causes of action, debts, demands or obligations, including costs and attorney's fees, which may be made against Landlord or against Landlord's title to the Demised Premises arising by reason of or in connection with, or resulting from, any alleged act or omission of Tenant or any person claiming under, by or through Tenant resulting from the development, construction or operation of the Building and Other Improvements, or from breach by Tenant of any covenant required to be performed by Tenant under this Lease; provided, however, Tenant shall not be required to indemnify and save harmless Landlord from or against any and all claims, debts, demands or obligations which may be made against Landlord or against Landlord's title to the Demised Premises arising by reason of, or in connection with, or resulting from any act or omission of Landlord.

ARTICLE 16.
RECONSTRUCTION

In the event of damage to or destruction of the Building or other improvements erected on the Demised Premises, the insurance proceeds, if any, shall be applied for reconstruction of the Building and Other Improvements. Tenant shall be required to restore the Building and Other Improvements within a reasonable time and in a reasonable manner, as nearly as possible to such condition as existed immediately prior to such damage or destruction. Any reconstruction or repair undertaken by Tenant pursuant to this Article XV shall be subject to the same terms and conditions

contained in this Lease related to the initial construction of the Building and Other Improvements, as applicable.

ARTICLE 17.
CONDEMNATION

If the Demised Premises or the Building shall be taken in whole or in part by or pursuant to governmental authority, or through exercise of the right of eminent domain or sold under threat thereof, any and all awards or sums granted in consideration or settlement for the Land and the improvements taken and/or damaged shall be equitably apportioned between Landlord and Tenant based on the relative values of the leasehold estate and the remainder interest with proper credit being given to the parties for any prior disbursements of such awards or sums including payments to the holder of a Leasehold Mortgage.

If the entire Demised Premises (inclusive of the Building) should be so taken or sold, this Lease shall terminate on the date that such taking or sale becomes final. If only a portion of the Demised Premises (including, without limitation, the parking areas) is so taken or sold, and the balance of the Demised Premises is not suitable for the operation of a rehabilitation hospital, or if by deprivation or limitation of any access thereto or therefrom the Demised Premises are rendered unsuitable for the operation of a rehabilitation hospital, Tenant may either elect to terminate this Lease by giving ninety (90) days advance notice to Landlord or to continue in possession of the remaining portion of the Demised Premises.

Nothing contained herein shall be deemed a waiver of Tenant's exclusive right to any and all awards for damages to, or taking of, improvements placed on the Demised Premises by Tenant and nothing herein shall be deemed as a waiver of the Landlord's exclusive right to any award for any portion of the Land taken or damaged.

ARTICLE 18.
DEFAULT BY TENANT

A. Events of Default Defined. The following shall be "Events of Default" under this Lease and the term "Events of Default" or "Default" shall mean, whenever they are used in this Lease, any one or more of the following events:

(1) Delinquency in the due and punctual payment of any rent or additional payment under this Lease when such rent shall become payable, and such default shall continue for ten (10) days after payment is due.

(2) Delinquency by the Tenant in the performance or compliance with any of the conditions or covenants contained in this Lease other than that referred to in subparagraph (a)(1) above for a period of thirty (30) days after written notice thereof from the Landlord to the Tenant, except for any default not susceptible of being cured within such thirty (30) day period, in which event the time permitted to the Tenant to cure such default shall be extended for so long as shall be reasonably necessary to cure such default, provided the Tenant commences

promptly and proceeds diligently to cure such default, and provided further that such period of time shall not be so extended as to jeopardize the interest of the Landlord in this Lease or the Leased Premises or so as to subject the Landlord or the Tenant to any civil or criminal liabilities.

(3) The filing by the Tenant of a voluntary petition in bankruptcy, or adjudication of the Tenant as a bankrupt, or assignment, partial or general, by the Tenant for the benefit of its creditors, or the entry by the Tenant into an agreement of composition with creditors, or the approval by a court of competent jurisdiction of a petition applicable to the Tenant in any proceeding for their reorganization instituted under the provisions of the general bankruptcy act, as amended, or under any similar act which may hereafter be enacted.

(4) The vacation or desertion or unoccupancy of the Demised Premises for a period of sixty (60) consecutive days.

(5) The assignment or subletting of the Leased Premises in violation of Article 21.

(6) Contravention of the use restriction provision contained in Article 7.

B. **Remedies on Default**. Whenever any event of default referred to in subparagraph (a) (1) Whenever any event of default referred to in subparagraph (a) (1) r act which may hereafter be enacted.

(1) Landlord may reenter and take possession of the Leased Premises without terminating this Lease, and sublease the Leased Premises for the account of the Tenant, holding the Tenant liable for the difference in the rent and other amounts payable by such sub-lessee in such sub-leasing and the rents and other amounts payable by the Tenant hereunder.

(2) Landlord may terminate this Lease and demand and collect from Tenant the entire unpaid balance of rent for the entire Lease Term, or any Option Term in effect, as the case may be, i.e. acceleration of all future rents due hereunder.

(3) Landlord may terminate this Lease and exclude the Tenant from possession of the Demised Premises and may lease the Demised Premises to another for the account of the Tenant, holding the Tenant liable for all rent and other payments due up to the effective date of such leasing and for the excess, if any, of the rent and other amounts payable by the Tenant under this Lease had the Lease Term or any renewal thereof not have been terminated over the rents and other amounts which are payable by such new lessee under such new lease.

(4) The remedies herein specified are to be exercised by the Landlord in pursuance of the availability of these remedies as provided for under the laws of the State of Tennessee; and in pursuance of these laws the Landlord may take whatever action at law and equity is available in the enforcement of these remedies, and otherwise

as may appear necessary or desirable to collect rents due, or to become due, or to enforce specific performance and observation of any obligation, agreement or covenant of the Tenant under this Lease Agreement.

C. **No Remedy Exclusive**. No remedy herein conferred upon or reserved to the Landlord is intended to be exclusive of any other available remedy or remedies, but each and every remedy shall be cumulative and alternative and shall be in addition to every other remedy given under this Lease, now or hereafter existing at law or in equity or by statute. No delay or omission to exercise any right or power shall be construed to be a waiver thereof, but any such right and power may be exercised from time to time as often as may be deemed expedient. In order to entitle the Landlord to exercise any remedy reserved to them in this Article, it shall not be necessary to give any notice other than such notice as may be herein expressly required.

D. **No Additional Waiver Implied By One Waiver**. In the event any agreement contained in this Lease should be breached and thereafter waived, such waiver shall be limited to the particular breach so waived and shall not be deemed to waive any other breach hereunder.

E. **Right of Entry**. Landlord and/or their representatives, may enter the Demised Premises at any reasonable time, before or after default by Tenant, for the purpose of taking possession after default, inspecting the Demised Premises, performing any work which the Landlord may elect to undertake made necessary by reason of the Tenant's default under the terms of this Lease, and exhibiting the Demised Premises for lease. Such right of entry may be exercised by the Landlord or their representatives without the same constituting an eviction of the Tenant in whole or in part.

F. **Reimbursement Of Unamortized Costs**. Anything to the contrary contained herein notwithstanding, if Tenant defaults under the terms of this Lease and Landlord exercises its remedy to terminate the Lease, Tenant shall receive a credit toward sums which it would otherwise owe to Landlord hereunder for the amount of the unamortized costs of the Improvements based on a _____ year amortization period; provided, however, notwithstanding the amount of the unamortized cost of the Improvements, the amount of the credit shall not exceed the fair market value of the Improvements on the date a payment is due. **[ACCOUNT/AUDITOR QUESTION ABOUT AMORTIZATION PERIOD]** (By way of example, if the cost of the Improvements is $16,000,000.00, and the amortization period for the Improvements is twenty (20) years, and the default occurs after year six, then the credit toward the sums owed by Tenant to Landlord for default on the Lease would be $11,200,000.00. (Calculated as $16,000,000.00 ÷ 20 = $800,000.00 x 14 = $11,200,000.00) (If the liability of the Tenant to Landlord for breach of the Lease is $769,500.00 (see example below), then Landlord shall owe Tenant $10,430,500.00 at termination of the Lease.))

(Further Example: Assuming that the rent owed by Tenant to Landlord in year six is $85,500.00 per year, then the balance owing to Landlord for the remainder of the lease term would be $769,500.00. (Calculated $85,500.00 x 9 Years (Remaining Lease Term) equals $769,500.00.)

ARTICLE 19.
DEFAULT BY LANDLORD

If Landlord shall fail to pay, within a reasonable time after the due date for same, any obligation paramount to this Lease or affecting the Demised Premises or shall fail promptly to remove any other lien or charge which could jeopardize the Tenant's right to possession of the Demised Premises as hereby granted, Tenant may pay the items in question after first giving Landlord written notice of such failure by certified mail and Landlord shall not have made such payment or removed such lien or other charge with thirty (30) days following receipt of notice thereof from Tenant. Any such payment shall entitle Tenant to be subrogated to the lien or charge of the item so paid. Landlord shall have an opportunity to contest the validity of any obligation paramount to this Lease or affecting the Demised Premises. If any payment is made by Tenant pursuant to this Article18, Landlord shall be liable for reimbursement to Tenant, together with interest at the prime rate as announced by Tenant's primary depository, promptly upon written demand to Landlord from Tenant.

ARTICLE 20.
TERMINATION OF LEASE; TITLE TO IMPROVEMENTS

Upon termination of this Lease, either by default of Tenant or expiration of the Term (subject to the provisions of Articles 5 and 16 hereof), the Improvements on the Demised Premises will be and become the property of the Landlord.

ARTICLE 21.
ASSIGNMENT AND SUBLETTING

A. Except as provided in this Article 21, without the prior written consent of Landlord, which consent shall not be unreasonably withheld, conditioned or delayed by Landlord, neither this Lease, nor any interest of Tenant in this Lease or in the Demised Premises, shall be sold, assigned, or otherwise transferred, directly or indirectly, whether by operation of law or otherwise. Factors Landlord may consider for an assignment or subletting of this Lease are the creditability and history of such assignee or subtenant in the rehabilitation hospital business, the financial strength and liquidity of the proposed assignee or subtenant, and such proposed assignee or subtenant's use of the Demised Premises solely as a rehabilitation hospital. In no event shall any assignment, transfer of sublease or license relieve Tenant of any liability or obligation under this Lease, which shall be and remain that of a primary obligor and not a guarantor or surety.

B. Without implying any authority of Tenant to assign this Lease, if this Lease is assigned pursuant to the provisions hereof, or if the Demised Premises or any part thereof is sublet or occupied by any person or entity other than Tenant, Landlord may, after an Event of Default has occurred and is continuing, collect rent from the assignee, subtenant or occupant, and apply the net amount collected to the rent due hereunder, but no such assignment, subletting, occupancy or collection shall be deemed a waiver of this covenant, or the acceptance of the assignee, subtenant or occupant as Tenant, or a release of Tenant from the further performance

by Tenant of the terms, covenants, and conditions on the part of Tenant to be observed or performed hereunder.

ARTICLE 22.
ADJACENT AREAS

Landlord shall maintain its real property adjacent to the Demised Premises in a reasonable manner and in a good and sightly condition to provide visually attractive surroundings to the Building. Subject to all easements granted or to be granted to Tenant in connection with this Lease, Landlord may use or improve the real property owned by Landlord adjacent to the Demised Premises, as Landlord so desires, provided that Tenant's use and enjoyment of the Demised Premises is not impaired as a result thereof.

ARTICLE 23.
NOTICES

All notices and communications hereunder shall be in writing and shall be deemed given: (a) on the date of delivery if delivered in person; (b) on the date placed with a nationally recognized overnight delivery service, such as FedEx or UPS; (c) on the date deposited in the United States mail if sent by registered or certified mail, postage prepaid; or (d) on the date sent by electronically-confirmed facsimile transmission. All such notices and communications shall be properly addressed as follows:

Tenant: West Tennessee Rehabilitation Hospital, LLC

_____
_____
_____
_____
_____

With a copy to:

_____
_____
_____
_____
_____
_____

Landlord: West Tennessee Healthcare, Inc.
620 Skyline Drive
Jackson, TN 38301
Attn: General Counsel
Telephone: (731) 541-9914

With a copy to: Rainey, Kizer, Reviere & Bell, P.L.C.
105 South Highland Avenue
Jackson, TN 38301
Attn: William C. Bell, Jr.
Telephone: (731) 423-2414

If sent by one of the herein-described means, notices shall be deemed received: (w) on the date delivered if given by personal delivery; (x) one (1) business day after being placed with a nationally recognized overnight delivery service; (y) two (2) business days after being deposited in the United States mail service. Either party may at any time change its Notice Address by sending a written notice to that effect by one of the above-described means to the other party stating the change and setting forth the new address or number.

ARTICLE 24.
SUCCESSORS AND ASSIGNS

The covenants, conditions and agreements contained in this Lease shall bind and inure to the benefit of Landlord and Tenant and their respective successors and permitted assigns; provided, however, that, subject to the terms of Article XX hereof, Tenant shall not assign or otherwise transfer its Leasehold Interest without the prior written consent of Landlord, which consent shall not be unreasonably withheld, conditioned nor delayed. Upon a transfer by Landlord or Tenant of its respective estate or interest in the Demised Premises or the Improvements, the transferring party (the "**Transferring Party**") shall notify the other party in writing of such transfer. The Transferring Party shall be and is hereby relieved from any breach of covenants or obligations under the Lease arising or occurring after the date of transfer of the Transferring Party's estate or interest in the Demised Premises or the Improvements. The provisions of this Article XXIV shall apply to each successive transfer of Landlord's or Tenant's interest or estate.

ARTICLE 25.
DISPUTES

Anything to the contrary contained herein notwithstanding, if any bona fide dispute arises concerning the performance by Tenant (or any other party on behalf of Tenant) of the obligations imposed upon Tenant under the terms of this Lease, the Tenant or any other party having an interest in this Lease shall be entitled to have such dispute resolved by the Chancery Court of Madison County, Tennessee. During the pendency of any such court proceeding, the grace periods otherwise specified herein for curing defaults shall be tolled if an appropriate bond acceptable to Landlord is posted with the court to assure reasonable performance of Tenant's obligation if the matter is resolved in favor of Landlord; provided, however, that this provision shall not be applicable if Landlord is materially prejudiced pending resolution of the dispute; provided further, however, that such tolling provision shall be applicable only to non-monetary defaults and shall not toll any grace period otherwise specified herein with respect to the payment of monetary defaults, which (unless otherwise ordered by a court of competent jurisdiction) shall be paid under protest in the event Tenant or any other party with an interest in this Lease disputes the propriety of any such payment.

If any action, suit, or other proceeding is instituted to remedy, prevent or obtain relief from a default in the performance by any party to this Lease of its obligations hereunder, the prevailing party shall be reimbursed by the other party hereto for all of such party's reasonable attorneys' fees incurred in each and every such action, suit, arbitration or other proceeding, including any and all appeals or petitions therefrom. As used in this Article, reasonable attorneys' fees shall be deemed to mean the full and actual costs of any legal services actually performed in connection with the matters involved, calculated on the basis of the usual fee charged by the attorney performing such service.

ARTICLE 26.
HAZARDOUS MATERIALS

Landlord shall be responsible for the costs and expenses of any and all penalties, fines, claims, liens, suits, liabilities, costs, judgments and expenses of every kind and nature (each a "**Claim**") as a result of any hazardous or toxic materials, substances or wastes ("**Hazardous Materials**") in existence on the Commencement Date, but not thereafter, under federal, state and local environmental laws and regulations, including but not limited to, the Comprehensive Environmental Response, Compensation and Liability Act of 1980 ("**CERCLA**"), Public Law No. 96-510, 94 Stat. 2767, 42 USC 7601 et seq. and the Superfund Amendments and Reauthorization Act of 1986 (SARA), Public Law No. 99-499, 100 Stat. 1613, the Toxic Substances Control Act, as amended, (15 U.S.C. § 2601 et seq.); the Hazardous Materials Transportation Act, as amended (49 U.S.C. § 1801 et seq.); the Clean Air Act, as amended, (42 U.S.C. § 7401 et seq.); the Clean Water Act, as amended (33 U.S.C. § 1251 et seq.); the Oil Pollution Act of 1990, as amended (33 U.S.C. § 2701 et seq.); and the Safe Drinking Water Act, as amended (42 U.S.C. § 1251 et seq.), as any of the foregoing may hereinafter be amended; any rule or regulation promulgated pursuant thereto, and any other present or future law, ordinance, rule, regulation, permit or permit condition, order or directive addressing environmental, health, or safety issues of or by the federal government or any state or other political subdivision thereof, or any agency, court or body of the federal government, or any state or political subdivision thereof, exercising executive, legislative, judicial, regulatory or administrative functions (collectively, the "**Environmental Laws**") with respect to Hazardous Materials located on, in, above or under the Demised Premises as of the date hereof.

Tenant shall construct the Building and Other Improvements and conduct all of its operations on the Demised Premises in accordance with all applicable laws, codes and regulations, including, without limitation, Environmental Laws. Tenant hereby covenants and agrees during the Term of this Lease not to bring, release, use or store Hazardous Materials in, on or above the Demised Premises, except in compliance with the Environmental Laws and permits required thereby.

Tenant shall indemnify, defend and hold the Landlord, its employees and agents harmless from and against any and all damages, penalties, fines, claims, liens, suits, liabilities, costs, judgments and expenses (including, without limitation, attorneys' fees) of every kind and nature suffered by or asserted against the Landlord as a result of any Hazardous Materials that Tenant brings, releases or uses on, in, above or under the Demised Premises in violation of the

Environmental Laws or permits required thereby and for any violations of the Environmental Laws after the Commencement Date.

ARTICLE 27.
SIGNAGE

Landlord retains the right from time to time to prescribe reasonable standards governing the size, shape, number, location, material and content of all exterior signs, decorations, fixtures and advertising devices on the Building, the Other Improvements, and Demised Premises. Tenant shall not decorate, paint, or in any other manner alter the exterior of the Building, and shall not install, affix or maintain any sign, decoration, fixture or other advertising device, on the exterior of the Building and on the Demised Premises without first obtaining Landlord's written consent (which consent shall not be unreasonably withheld, conditioned nor delayed) and complying in all respects with the aforesaid standards. Signage also must comply with any restrictive covenants affecting the Demised Premises and zoning ordinances of the City of Jackson.

All signs installed by or on behalf of Tenant shall be removed by Tenant at the expiration or earlier termination of this Lease, and Tenant shall repair any damage caused by such removal and restore the Demised Premises and/or the exterior of the Building to its original order and condition.

ARTICLE 28.
MEMORANDUM OF LEASE

Upon execution of this Lease, the parties hereby agree to execute, acknowledge and deliver for recording purposes a memorandum of lease in substantially the form attached hereto as Exhibit D. No such memorandum shall include any financial terms of this Lease. Recording, filing and like charges and any stamp, charge for recording, transfer or other tax shall be paid by Tenant. In the event of termination of this Lease, within thirty (30) days after written request from Landlord, Tenant agrees to execute, acknowledge and deliver to Landlord an agreement terminating such memorandum of lease of record. If Tenant fails to execute such agreement within the thirty (30) day period or fails to notify Landlord within the thirty (30) day period of its reasons for refusing to execute such agreement, Landlord is hereby authorized to execute and record such agreement for the sole purpose of terminating the memorandum of lease of record. This provision shall survive any termination of the Lease.

ARTICLE 29.
NET LEASE

The Rent payable under Article 2 of this Lease shall be absolutely net to Landlord so as to yield to Landlord in each year during the Term, the Rent so specified, free of any charges, assessments, impositions or deductions of any kind charged, assessed, or imposed on or against the Demised Premises. Except as otherwise specifically provided for by any provision of this Lease, all costs, expenses and obligations of any kind which may arise or become due during the Lease Term relating to the maintenance and operation of the Demised Premises, including all

alterations, repairs, reconstruction and replacements as provided in this Lease, shall be paid by Tenant, and Landlord shall be indemnified and saved harmless by Tenant from and against such costs, expenses and obligations.

ARTICLE 30.
LEASE CONDITIONED UPON GOVERNMENT APPROVALS

Notwithstanding anything contained in this Lease or elsewhere to the contrary, Tenant's obligations and Landlord's obligations under this Lease shall be conditioned upon Tenant's attainment of all governmental, quasi-governmental and other approvals (including the issuance of a Certificate of Need by the State of Tennessee) and permits necessary for construction of the Building and its use thereof as a rehabilitation hospital building (collectively, the "**Approvals**") on or before _____, ____ (the "**Approvals Deadline**"). Tenant agrees to act diligently, at its expense, in the process of obtaining the Approvals, and Landlord agrees to assist as needed and as requested, in obtaining the Approvals.

Denial of one or more Approvals or the failure of Tenant to obtain all Approvals by the Approvals Deadline shall entitle Tenant or Landlord on each occasion to terminate this Lease upon written notice to the other party, given within thirty (30) days after a denial or the Approvals Deadline, as applicable. Upon such termination, neither Landlord nor Tenant shall have any further obligations hereunder.

Notwithstanding the foregoing, Tenant shall have the right, in its sole discretion, to extend the Approvals Deadline one (1) or more times, not to exceed a total of one hundred eighty (180) days, by providing written notice to Landlord of each such extension at least ten (10) days prior to the then-current Approvals Deadline.

ARTICLE 31.
FINANCIAL STATEMENTS

Tenant agrees to provide its most recent financial statements to Lessor within fifteen (15) days following request by Lessor therefore; provided, however, that Tenant shall not be obligated to provide financial statements more than one (1) time in any twelve (12) consecutive month period unless it is in default under this Lease.

ARTICLE 32.
COVENANT NOT TO COMPETE; NO EXCLUSIVE RIGHT TO DEVELOP

Each of Tenant and HealthSouth Corporation agrees that, except for the Demised Premises, neither it nor any of its affiliates will own, manage or operate a rehabilitation hospital within a thirty (30) mile radius of the Demised Premises without first obtaining the express, written consent of Landlord, which consent may be withheld in Landlord's sole discretion.

Each of Tenant and HealthSouth Corporation acknowledges and agrees that nothing contained in this Lease shall be construed to grant to Tenant or HealthSouth Corporation any

rights to develop or coordinate the development of any other improvements on Landlord's campus.

ARTICLE 33.
MISCELLANEOUS

This Lease shall be subject to the following:

A. The liability of the members of Tenant under this Lease shall be and is hereby limited to such members' interest in Tenant, and no other assets of the members of Tenant shall be affected by reason of any liability which Tenant or said members may have to Landlord or any other person by reason of this Lease, the obligations of Tenant contained herein or the execution hereof.

B. This Lease contains the entire agreement of the parties as to the subject matter herein and supersedes all prior agreements, whether written or oral. This Lease may not be modified in any manner other than by agreement in writing signed by all parties hereto, or their successors in interest or permitted assigns.

C. Tenant shall conform to and observe all lawful ordinances, rules and regulations of the United States of America, State of Tennessee and all public authorities, boards or offices, relating to the Demised Premises or the improvements thereon or the use thereof; provided, however, that nothing herein contained shall be construed as preventing or interfering with the contestation by Tenant, at its own expense, of any such ordinance, rule or regulation that it may consider unlawful or oppressive, and Tenant shall not be considered in default with respect to such contested matter so long as the matter shall remain undetermined by final judgment.

D. No waiver of any condition or covenant in this Lease, or of any breach thereof, shall be taken to constitute a waiver of any subsequent breach. No payment by Landlord, in case of default on the part of Tenant in that respect, of any taxes, assessments, public charges, or premiums of insurance, or the payment of any amount herein provided to be paid other than Rent, or in the procuring of insurance as hereinabove provided, shall constitute or be construed as a waiver or covenant by Landlord of the default of Tenant in that respect.

E. Whenever Tenant requests any consent, permission or approval which may be required or desired by Tenant pursuant to the provisions hereof, Landlord shall not unreasonably withhold, condition nor delay the granting of such consent, permission or approval.

F. During the Term of this Lease, only Tenant shall have the right to take deductions on its tax returns with respect to the Improvements (including the Building), structures, improvements, changes, alterations, additions, repairs and installations which are located upon the Demised Premises and depreciation thereof.

G. All covenants, promises, conditions and obligations herein contained or implied by law are covenants running with the land and shall attach and bind and inure to the benefit of the Landlord and Tenant and their respective heirs, legal representatives, successors and assigns, except as otherwise provided herein.

H. This Lease shall be governed by and construed in accordance with the laws of the State of Tennessee.

I. There are no oral or verbal understandings among Landlord and Tenant concerning the subject matter of this Lease, and any amendment, modification or supplement to this Lease must be in writing.

J. Landlord's or Tenant's failure to exercise any rights or options provided herein under or by law does not constitute a permanent waiver of that right or option.

K. Should Tenant, or any of Tenant's successors in interest, hold over on the Demised Premises, or any part thereof, after the expiration of the Term of this Lease with the permission of Landlord, unless otherwise agreed in writing, such holding over shall constitute and be construed as a tenancy from month-to-month only, subject to all the terms and provisions of this Lease (to the extent applicable to a month-to-month tenancy) and shall not be an extension of the Term of this Lease.

Rent for such month-to-month tenancy shall be one-twelfth ($1/12^{th}$) of the then annual fair market rental value of the Demised Premises, payable in advance on the first day of each calendar month during the term of such month-to-month tenancy, with all other monetary obligations being due and payable as herein provided. If Landlord and Tenant cannot agree on the annual fair market rental value of the Demised Premises, it shall be determined by appraisal as set out in Article XX above. The inclusion of this Paragraph shall not be construed as Landlord's consent for Tenant to hold over. Any such month-to-month tenancy may be terminated by either party hereto giving the other party thirty (30) days prior written notice of such termination.

L. It is the intention of Landlord and Tenant to conform strictly to applicable usury laws. Accordingly, if the transaction contemplated hereby would be usurious in any respect under applicable law, then, in that event, notwithstanding anything contained herein or in any agreement entered into in connection with or as-security for this Lease to the contrary, it is agreed that the aggregate of all consideration which constitutes interest under applicable law that is taken, reserved, contracted for, charged, or received by Landlord under this Lease or under any of the aforesaid agreements securing this Lease or otherwise entered into in connection with this Lease shall under no circumstances exceed the maximum amount of interest allowed by applicable law, and any excess shall be credited on this Lease by the Landlord to any rent or other sum which is not interest under applicable law owing by Tenant to Landlord hereunder or, at the option of Landlord, refunded to Tenant, and in no event shall any consideration paid by Tenant to Landlord hereunder that constitutes interest ever include more than the maximum amount allowed by applicable law.

M. If any clause or provision of this Lease is illegal, invalid, or unenforceable under any present or future laws effective during the Term of this Lease, then and in that event, it is the intention of the parties hereto that the remainder of this Lease shall not be affected thereby, and it is also the intention of the parties to this Lease that in lieu of each clause or provision of this Lease that is illegal, invalid or unenforceable, there be added as a part of this Lease a clause or provision as close in meaning to such stricken clause or provision as will be legal, valid and enforceable.

N. Words of any gender used in this Lease shall be held and construed to include any other gender, and words in the singular number shall be held to include the plural, unless the context otherwise requires.

O. Except as otherwise herein expressly provided, time is of the essence with respect to each provision of this Lease.

P. Tenant agrees to comply with all restrictive covenants on the Land.

Q. **Change In Law**. If any legislative, judicial, or regulatory change or determination, whether federal or state, has or would have any material adverse impact on either party in connection with the performance of this Lease, or if performance by either party with any term or provision of this Lease should be deemed, in the reasonable opinion of Landlord's counsel, or reasonable opinion of Tenant's counsel, a violation or potential violation of any federal or state law, then either party shall have the right to require the other party to renegotiate the terms of this Lease, to make this Lease compliant with appropriate federal or state law. Such renegotiated terms will become effective not later than thirty (30) days after receipt of written notice of such request for renegotiation. If the parties fail to reach an agreement satisfactory to both parties within such thirty (30) day period after the receipt of the request for renegotiation, then either party may terminate this Lease upon thirty (30) days notice after the inability of the parties to reach a renegotiated Lease, without further liability or obligation, and the provisions of Article XIX shall apply as to the rights and obligations of the parties thereafter.

R. **Tobacco-Free Campus**. The Tenant agrees that the Demised Premises will be used and occupied in compliance with Landlord's Tobacco-Free Campus Policy.

S. **Landlord's Campus Policies**. The Tenant agrees to comply with other campus policies of Landlord, as established from time to time, so long as such policies do not interfere with Tenant's operation of its rehabilitation hospital in accordance with applicable rules and regulations.

[Signature Page Follows]

IN WITNESS WHEREOF, the parties hereto have executed this Lease as of the day and year first above written.

LANDLORD:

WEST TENNESSEE HEALTHCARE, INC.,
a Tennessee nonprofit corporation and governmental instrumentality of Jackson-Madison County General Hospital District

By: _____
Title: _____

TENANT:

JV, LLC,
a Delaware Limited Liability Company

By: _____
Title: _____

EXHIBIT A

[Legal Description of the Land]

EXHIBIT B

[Site Plan depicting the location of the Building]

EXHIBIT C

[Description of Plans and Specifications]

EXHIBIT D

[Form of Memorandum of Lease]

Attachment B.II.B.
CEO Letter-Delicense Beds

620 Skyline Drive • Jackson, Tennessee 38301 • 731-541-5000 • www.wth.org

October 8, 2015

Ms. Melanie Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

RE: West Tennessee Rehabilitation Center-Certificate of Need
Delicensing of 48 beds-Jackson-Madison County General Hospital.

Dear Ms. Hill:

The applicant for the above stated certificate of need is the West Tennessee Rehabilitation Hospital, LLC. The applicant is jointly owned by the Jackson-Madison County General Hospital District and HealthSouth Corporation. Upon approval by the Tennessee Health Services and Development Agency and completion of the project, the Jackson-Madison County General Hospital will delicense 48 inpatient rehabilitation beds.

If you have any questions, feel free to telephone me. I may be reached at (731) 541-6730.

Sincerely,

Bobby Arnold
President and CEO

Attachment B.III.(A)
Plot Plan

HEALTHSOUTH

48 BED REHABILITATION HOSPITAL
SITE PLAN
JACKSON, TN

SITE PLAN

FOREST COVE
(60' RIGHT-OF-WAY)
10' SETBACK
MAIN ENTRANCE
W. FOREST AVENUE
(60' RIGHT-OF-WAY)
EXISTING R.O.W.
20' DEDICATED R.O.W.
20' SETBACK
48 BED REHABILITATION HOSPITAL
OUTDOOR THERAPY COURT
GAZEBO
SERVICE COURT
Planter
Grass
Grass
10' SETBACK
EXISTING TOWER
PATIENT TRANSFER
10' SETBACK
EXISTING OVERHEAD ELECTRIC
EXISTING PARKING LOT
10' SETBACK
10' SETBACK
LINDA VISTA DR.
(60' RIGHT-OF-WAY)

SCALE: 1"=80'

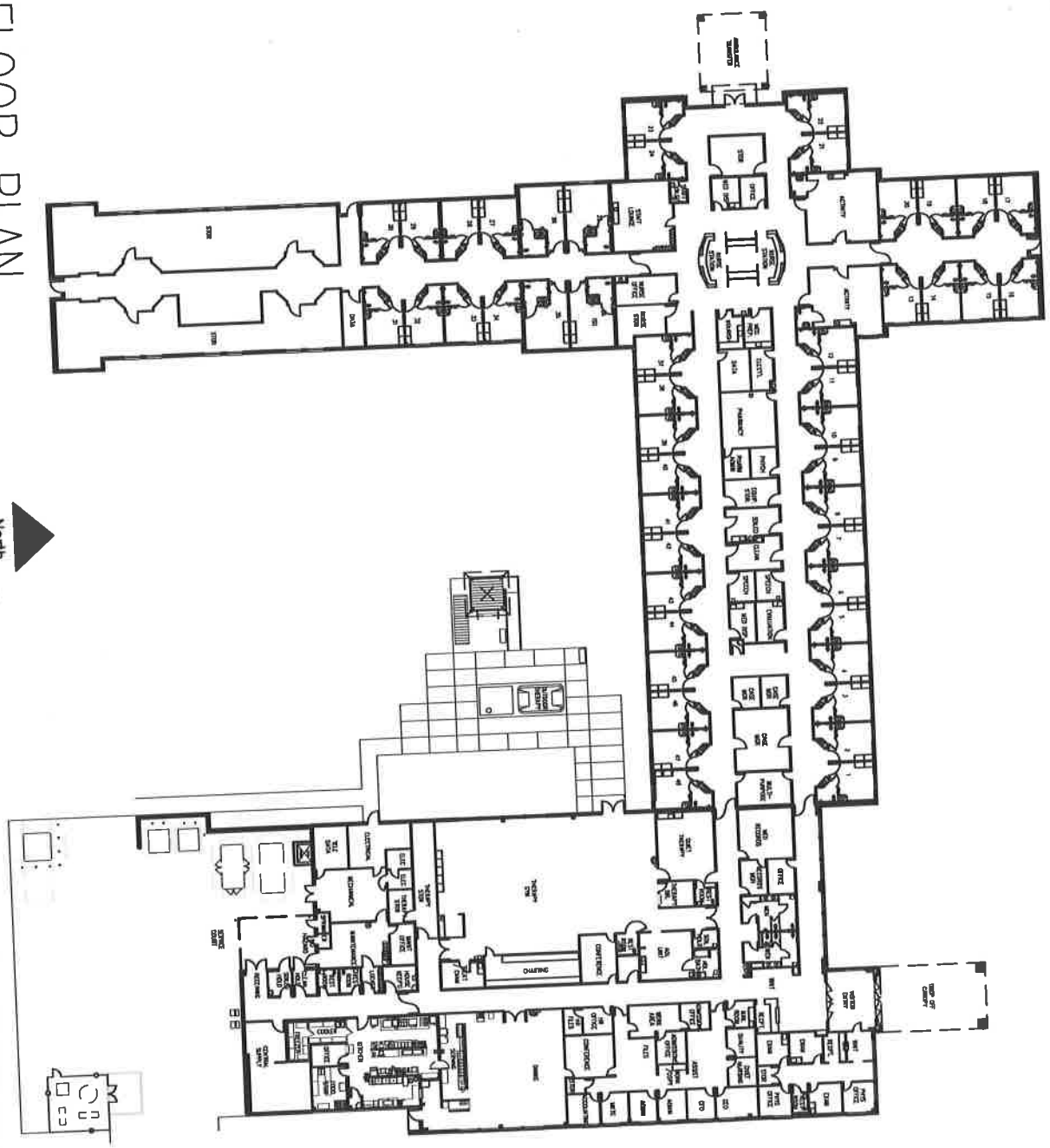
5.59 Acres

Attachment B.IV.

Floor Plans

FLOOR PLAN

SCALE: NTS



48 BED REHABILITATION HOSPITAL 59,450 GSF

48 BED REHABILITATION HOSPITAL
FLOOR PLAN
JACKSON, TN

HEALTHSOUTH®

PATIENT ROOM REQUIREMENTS (FGI 2.6-2.2.2.2)

GROSS ROOM AREA: 199 S.F.

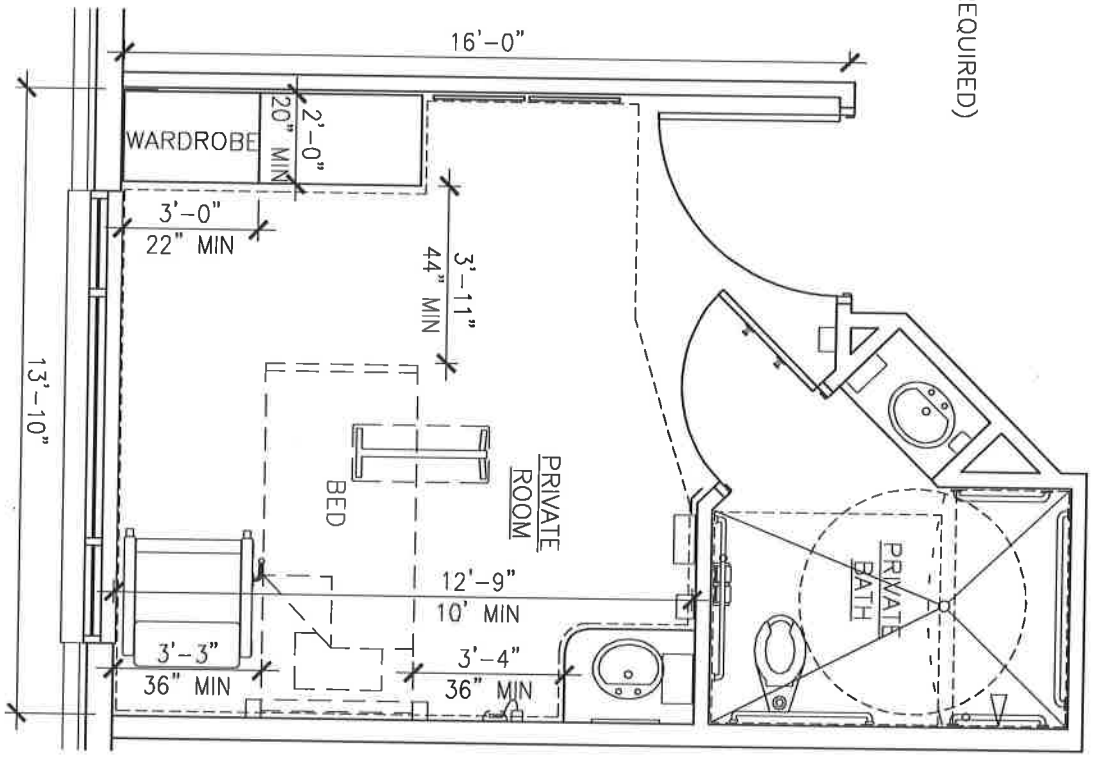
NET ROOM AREA: 148 S.F. (140 S.F. REQUIRED)

GLASS AREA REQUIRED: (FGI 2.1-7.2.2.5)
148 S.F. x .08 = 11.8 S.F.

GLASS AREA PROVIDED: 28.89 S.F.

PRIVATE ROOM PLAN

SCALE: NTS



FLOOR PLAN

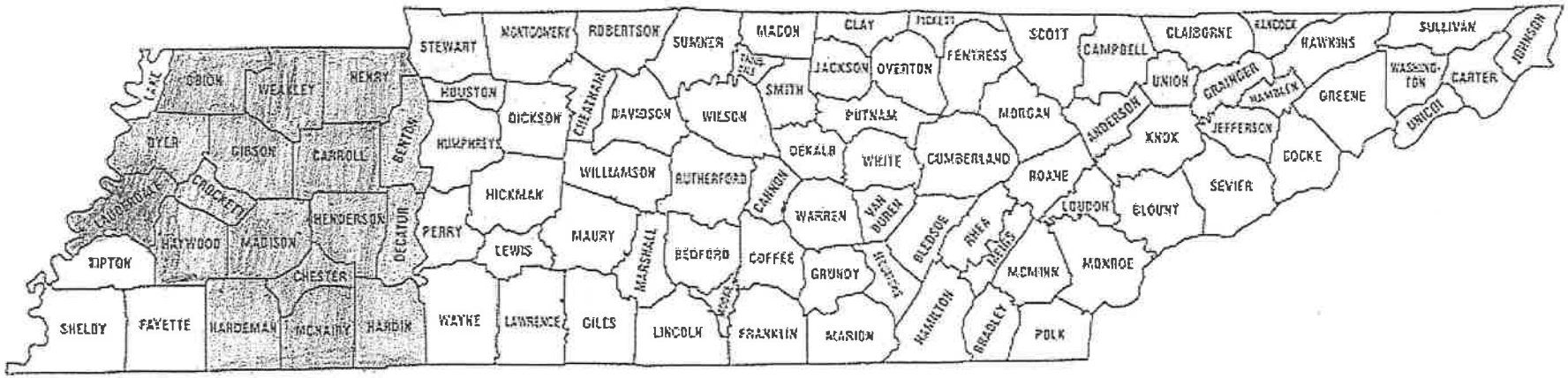
48 BED REHABILITATION HOSPITAL
FLOOR PLAN
JACKSON, TN

HEALTHSOUTH.

Attachment C. Need 3.

Map of Tennessee

State of Tennessee



Attachment C.
Economic Feasibility
1. Project Costs

FREDERICK & ASSOCIATES
ARCHITECTS

October 9, 2015

Mrs. Elizabeth Mann
HEALTHSOUTH Corporation
3660 Grandview PKWY
Suite 200
Birmingham, AL 35243

RE: HEALTHSOUTH Rehabilitation Hospital
Franklin, TN

Dear Mrs. Mann,

As part of the Certificate of Need process, please accept this letter of verification for construction cost and code compliance for the development of a 48-bed including 10 bed shell area, freestanding inpatient rehabilitation hospital in Jackson (Madison County), Tennessee.

The new hospital is expected to be 59,450 (53,330 sf + 6120 sf shell) square feet and we estimate construction costs, for the building only (not including site development costs) will be $12,730,623.00 which is $214.14 per square foot. We also estimate architectural and engineering costs will be $1,908,000 (including civil engineering, Survey, Construction Testing and Permit). Based upon our experience, we believe that the construction cost for this project is reasonable and consistent with construction costs for similar facilities.

We referenced the 2015 RS Means guidelines for cost of construction which indicates the median number for General Hospital construction is $214.14 per square foot for this geographic location.

The project will be designed and construction documents will be prepared to adhere to the current applicable codes;
The State of Tennessee Department of Health. Board for Licensing Health Care Facilities;

- 2012 International Building Code.
- 2012 National Fire Protection Code (NFPA) NFPA 1 including Annex A which code incorporates the 2006 edition of the Life Safety Code.
- 2006 International Mechanical Code.
- 2006 International Plumbing Code.
- 2006 International Fuel and Gas Code.

- 2010 Guidelines for Design and Construction of Health Care Facilities (AIA).
- 2005 National Electrical Code.
- 2009 U.S. Public Health Service Code. The handicap code is required by T.C.A. section 68-120-204(a) for all new and existing facilities are subject to the requirements of the 1999 North Carolina Handicapped Accessibility Codes with 2004 Amendments and 2010 Americans with Disabilities Act (A.D.A.)

City of Jackson Building Codes;

- 2012 International Energy Conservation Code.
- 2012 International Mechanical Code.
- 2012 International Fuel and Gas Code
- 2012 International Plumbing Code
- 2012 International Fire Codes (NFPA)
- 2009 ICC/ANSI A117.1 Accessible and Usable Buildings and Facilities.
- 2011 National Electrical Code.

We are pleased to assist you and HEALTHSOUTH in maintaining high standards of quality in design and operation of your facility.

Sincerely,

Fred C. Frederick, AIA
Principal

Cc; File

Attachment C.
Economic Feasibility
2.E. Documentation of Funding

HEALTHSOUTH®

October 10, 2015

Melanie M. Hill
Executive Director
Health Services and Development Agency
State of Tennessee
500 Deaderick Street, Suite 850
Nashville, TN 37243

RE: West Tennessee Rehabilitation Hospital, LLC Certificate of Need Application; Availability of Funds

Dear Ms. Hill:

This letter serves as confirmation that, with respect to the above-referenced project, HealthSouth Corporation, a partner in West Tennessee Rehabilitation Hospital, LLC, has available funds and will commit these funds for this project.

In the first six months of 2015 HealthSouth Corporation's operating activities had generated $204.9 Million and as of June 30 the Company had $45.5 Million of unrestricted cash on its balance sheet. HealthSouth Corporation has at its discretion a $600 Million Revolving Credit Facility. Currently, over $400 Million is available under this credit facility. Existing cash, cash flow from operations, and funds available under the credit facility offer more than adequate funds for the proposed project.

In addition to the commitment for the above noted project, HealthSouth Corporation is also committed to providing the necessary working capital for this proposed hospital as well as funding any operating deficits and pre-opening costs. HealthSouth Corporation has designated funds to cover 50% of the total project costs (as per the requirements of the partnership), which are expected to be approximately $34.3 Million. HealthSouth Corporation has sufficient resources to fully fund these expenditures in addition to its other ongoing obligations.

Sincerely yours,

Edmund Fay
Senior Vice President and Treasurer

3660 Grandview Parkway, Suite 200 • Birmingham, AL 35243
205 967-7116 • Fax 205 262-8708
www.healthsouth.com

West Tennessee Healthcare

620 Skyline Drive • Jackson, Tennessee 38301 • 731-541-5000 • www.wth.org

October 8, 2015

Ms. Melanie Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

RE: Certificate of Need Funding
West Tennessee Rehabilitation Center

Dear MS. Hill:

The applicant for the above stated project is the West Tennessee Rehabilitation Hospital, LLC. The applicant is jointly owned by the Jackson-Madison County General Hospital District and HealthSouth Corporation. The purpose of this letter is to verify that the Jackson-Madison County General Hospital will fund 50 percent of the total project costs or $17,164,590 for this Certificate of Need from cash reserves of the Jackson-Madison County General Hospital District. The District has available funds for this project in the amount of approximately $347,000,000 on 30 June 2015 to cover the estimated project costs.

If you have any questions, feel free to telephone me. I may be reached at (731) 541-6733.

Sincerely,

Jeff Blankenship
Vice President and Chief Financial Officer

HEALTHSOUTH

October 10, 2015

Melanie M. Hill
Executive Director
Health Services and Development Agency
State of Tennessee
500 Deaderick Street, Suite 850
Nashville, TN 37243

RE: West Tennessee Rehabilitation Hospital, LLC Certificate of Need Application; Availability of Funds

Dear Ms. Hill:

This letter serves as confirmation that, with respect to the above-referenced project, HealthSouth Corporation, a partner in West Tennessee Rehabilitation Hospital, LLC, has available funds and will commit these funds for this project.

In the first six months of 2015 HealthSouth Corporation's operating activities had generated $204.9 Million and as of June 30 the Company had $45.5 Million of unrestricted cash on its balance sheet. HealthSouth Corporation has at its discretion a $600 Million Revolving Credit Facility. Currently, over $400 Million is available under this credit facility. Existing cash, cash flow from operations, and funds available under the credit facility offer more than adequate funds for the proposed project.

In addition to the commitment for the above noted project, HealthSouth Corporation is also committed to providing the necessary working capital for this proposed hospital as well as funding any operating deficits and pre-opening costs. HealthSouth Corporation has designated funds to cover 50% of the total project costs (as per the requirements of the partnership), which are expected to be approximately $34.3 Million. HealthSouth Corporation has sufficient resources to fully fund these expenditures in addition to its other ongoing obligations.

Sincerely yours,

Edmund Fay
Senior Vice President and Treasurer

3660 Grandview Parkway, Suite 200 • Birmingham, AL 35243
205 967-7116 • Fax 205 262-8708
www.healthsouth.com

Attachment C.
Economic Feasibility 10

U.S. Securities and Exchange Commission
Form 10-K HealthSouth Corporation

West Tennessee Healthcare and Related Affiliates
Audited Financial Statements and Supplemental Schedules
June 30, 2014 and 2013

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2014
Commission File Number 001-10315

HealthSouth Corporation
(Exact Name of Registrant as Specified in its Charter)

Delaware	**63-0860407**
(State or Other Jurisdiction of Incorporation or Organization)	**(I.R.S. Employer Identification No.)**
3660 Grandview Parkway, Suite 200 Birmingham, Alabama	**35243**
(Address of Principal Executive Offices)	**(Zip Code)**

(205) 967-7116
(Registrant's telephone number)

Securities Registered Pursuant to Section 12(b) of the Act:

Title of each class	**Name of each exchange on which registered**
Common Stock, $0.01 par value	New York Stock Exchange

Securities Registered Pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer," and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒ Accelerated filer ☐ Non-Accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Exchange Act Rule 12b-2). Yes ☐ No ☒

The aggregate market value of common stock held by non-affiliates of the registrant as of the last business day of the registrant's most recently completed second fiscal quarter was approximately $3.1 billion. For purposes of the foregoing calculation only, executive officers and directors of the registrant have been deemed to be affiliates. There were 87,488,636 shares of common stock of the registrant outstanding, net of treasury shares, as of February 17, 2015.

DOCUMENTS INCORPORATED BY REFERENCE

The definitive proxy statement relating to the registrant's 2015 annual meeting of stockholders is incorporated by reference in Part III to the extent described therein.

TABLE OF CONTENTS

NOTE TO READERS

As used in this report, the terms "HealthSouth," "we," "us," "our," and the "Company" refer to HealthSouth Corporation and its consolidated subsidiaries, unless otherwise stated or indicated by context. This drafting style is suggested by the Securities and Exchange Commission and is not meant to imply that HealthSouth Corporation, the publicly traded parent company, owns or operates any specific asset, business, or property. The hospitals, operations, and businesses described in this filing are primarily owned and operated by subsidiaries of the parent company. In addition, we use the term "HealthSouth Corporation" to refer to HealthSouth Corporation alone wherever a distinction between HealthSouth Corporation and its subsidiaries is required or aids in the understanding of this filing.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This annual report contains historical information, as well as forward-looking statements that involve known and unknown risks and relate to, among other things, future events, changes to Medicare reimbursement and other healthcare laws and regulations from time to time, our business strategy, our dividend and stock repurchase strategies, our financial plans, our growth plans, our future financial performance, our projected business results, or our projected capital expenditures. In some cases, the reader can identify forward-looking statements by terminology such as "may," "will," "should," "expects," "plans," "anticipates," "believes," "estimates," "predicts," "targets," "potential," or "continue" or the negative of these terms or other comparable terminology. Such forward-looking statements are necessarily estimates based upon current information and involve a number of risks and uncertainties, many of which are beyond our control. Any forward-looking statement is based on information current as of the date of this report and speaks only as of the date on which such statement is made. Actual events or results may differ materially from the results anticipated in these forward-looking statements as a result of a variety of factors. While it is impossible to identify all such factors, factors that could cause actual results to differ materially from those estimated by us include, but are not limited to, the following:

- each of the factors discussed in Item 1A, *Risk Factors*; as well as uncertainties and factors discussed elsewhere in this Form 10-K, in our other filings from time to time with the SEC, or in materials incorporated therein by reference;
- changes in the rules and regulations of the healthcare industry at either or both of the federal and state levels, including those contemplated now and in the future as part of national healthcare reform and deficit reduction such as the reinstatement of the "75% Rule" or the introduction of site neutral payments with skilled nursing facilities for certain conditions, and related increases in the costs of complying with such changes;
- reductions or delays in, or suspension of, reimbursement for our services by governmental or private payors, including our ability to obtain and retain favorable arrangements with third-party payors and our exposure to the effects of Medicare claims audits for services previously provided;
- increased costs of regulatory compliance and compliance monitoring in the healthcare industry, including the costs of investigating and defending asserted claims, whether meritorious or not;
- our ability to attract and retain nurses, therapists, and other healthcare professionals in a highly competitive environment with often severe staffing shortages and the impact on our labor expenses from potential union activity and staffing recruitment and retention;
- competitive pressures in the healthcare industry and our response to those pressures;
- our ability to successfully complete and integrate de novo developments, acquisitions, investments, and joint ventures consistent with our growth strategy, including realization of anticipated revenues, cost savings, and productivity improvements arising from the related operations;
- any adverse outcome of various lawsuits, claims, and legal or regulatory proceedings, including the ongoing investigations initiated by the U.S. Department of Health and Human Services, Office of the Inspector General;
- increased costs of defending and insuring against alleged professional liability and other claims and the ability to predict the costs related to such claims;
- potential incidents affecting the proper operation, availability, or security of our information systems;
- the price of our common or preferred stock as it affects our willingness and ability to repurchase shares and the financial and accounting effects of any repurchases;
- our ability and willingness to continue to declare and pay dividends on our common stock;
- our ability to successfully integrate Encompass Home Health and Hospice, including the realization of anticipated benefits from the acquisition and avoidance of unanticipated difficulties, costs, or liabilities that could arise from the acquisition or integration;
- our ability to attract and retain key management personnel; and
- general conditions in the economy and capital markets, including any instability or uncertainty related to governmental impasse over approval of the United States federal budget or an increase to the debt ceiling.

The cautionary statements referred to in this section also should be considered in connection with any subsequent written or oral forward-looking statements that may be issued by us or persons acting on our behalf. We undertake no duty to update these forward-looking statements, even though our situation may change in the future. Furthermore, we cannot guarantee future results, events, levels of activity, performance, or achievements.

PART I

Item 1. Business.

Overview of the Company

General

HealthSouth Corporation is the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals. While our national network of inpatient hospitals stretches across 29 states and Puerto Rico, our inpatient hospitals are concentrated in the eastern half of the United States and Texas. With the acquisition of Encompass discussed below, HealthSouth operates in 33 states across the country and in Puerto Rico and serves patients through its network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies. HealthSouth was organized as a Delaware corporation in February 1984. Our principal executive offices are located at 3660 Grandview Parkway, Birmingham, Alabama 35243, and the telephone number of our principal executive offices is (205) 967-7116.

In addition to the discussion here, we encourage the reader to review Item 1A, *Risk Factors*, Item 2, *Properties*, and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, which highlight additional considerations about HealthSouth.

The table below provides detail on our hospitals and selected operating and financial data. Because the Encompass acquisition took place on December 31, 2014, our consolidated results of operations do not include the 2014 results of operations of Encompass. Home health and hospice, including our existing 25 hospital-based home health agencies, will represent a separate operating segment for us beginning in the first quarter of 2015. See Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Results of Operations."

	For the Year Ended December 31,		
	2014	2013	2012
	(Actual Amounts)		
Consolidated data:			
Number of inpatient rehabilitation hospitals [(1)]	107	103	100
Number of hospital-based home health agencies	25	25	25
Number of inpatient rehabilitation units managed by us through management contracts	3	3	3
Discharges	134,515	129,988	123,854
Outpatient visits	739,227	806,631	880,182
Number of licensed beds [(2)]	7,095	6,825	6,656
	(In Millions)		
Net operating revenues:			
Net patient revenue - inpatient	$ 2,272.5	$ 2,130.8	$ 2,012.6
Net patient revenue - outpatient and other	133.4	142.4	149.3
Net operating revenues	$ 2,405.9	$ 2,273.2	$ 2,161.9

(1) Including 1, 2, and 2 hospitals as of December 31, 2014, 2013, and 2012, respectively, that operate as joint ventures which we account for using the equity method of accounting

(2) Excluding 41, 151, and 151 licensed beds as of December 31, 2014, 2013, and 2012, respectively, of hospitals that operate as joint ventures which we account for using the equity method of accounting

Our inpatient rehabilitation hospitals offer specialized rehabilitative care across a wide array of diagnoses and deliver comprehensive, high-quality, cost-effective patient care services. Substantially all (92%) of the patients we serve are admitted from acute care hospitals following physician referrals for specific acute inpatient rehabilitative care. The majority of those patients have experienced significant physical and cognitive disabilities or injuries due to medical conditions, such as strokes, hip fractures, and a variety of debilitating neurological conditions, that are generally nondiscretionary in nature and require rehabilitative healthcare services in an inpatient setting. Our teams of highly skilled nurses and physical, occupational, and

speech therapists utilize proven technology and clinical protocols with the objective of returning patients to home and work. Patient care is provided by nursing and therapy staff as directed by physician orders while case managers monitor each patient's progress and provide documentation and oversight of patient status, achievement of goals, discharge planning, and functional outcomes. Our hospitals provide a comprehensive interdisciplinary clinical approach to treatment that leads to a higher level of care and superior outcomes.

Encompass Acquisition

On December 31, 2014, we completed the previously announced acquisition of EHHI Holdings, Inc. ("EHHI") and its Encompass Home Health and Hospice business ("Encompass"). In the acquisition, we acquired, for cash, all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to HealthSouth Home Health Holdings, Inc. ("Holdings"), a subsidiary of HealthSouth and now indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. These certain sellers were members of Encompass management, including April Anthony, the Chief Executive Officer of Encompass. These sellers contributed a portion of their shares of common stock of EHHI, valued at approximately $64.5 million, in exchange for shares of common stock of Holdings. As a result of that contribution, they hold approximately 16.7% of the outstanding common stock of Holdings, while HealthSouth owns the remainder. In addition, Ms. Anthony and certain other employees of Encompass entered into amended and restated employment agreements, each agreement having an initial term of three years.

Encompass is a leading provider of home health and hospice services operating in 135 locations across 12 states. Encompass has approximately 4,900 employees making more than 2.1 million patient visits annually. For the year ended December 31, 2014, Encompass had total revenues of approximately $369 million, which are not included in the accompanying consolidated statement of operations.

Encompass provides:

- home health services - a comprehensive range of Medicare-certified home nursing services to adult patients in need of care. These services include, among others, skilled nursing, physical, occupational and speech therapy, medical social work, and home health aide services. Encompass also provides specialized home care services in Texas and Kansas for pediatric patients with severe medical conditions. Encompass' home health services have historically represented a substantial portion of its revenues. For the year ended December 31, 2014, these services represented approximately 94% of Encompass' total revenues.

- hospice services - primarily in-home services to terminally ill patients and their families to address the patients' physical needs, including pain control and symptom management, and to provide emotional and spiritual support. For the year ended December 31, 2014, these services represented approximately 6% of Encompass' total revenues.

In terms of the industry, home health and hospice comprise a broad range of post-acute services. Home health services focus on the provision of home-based patient care, including skilled nursing care, physical, occupational and speech therapy, medical social work, and home health aide services. Home health service providers include facility-based agencies, such as hospitals, rehabilitation facilities and government agencies, home-based companies, visiting nurse associations, and nurse registries. Hospice services provide home-based and facility-based physical and emotional support for terminally ill patients and their families, providing services that include medical care, pain management, and emotional and spiritual support.

We believe Encompass will provide us with a high-quality, scalable asset that is capable of participating in the consolidation of the highly fragmented home health industry. Encompass has demonstrated an ability to acquire under-performing operations and incorporate them into its existing platform. As part of HealthSouth, we believe Encompass will be able to consider more numerous and significant home health and hospice acquisition opportunities given our strong cash flows from operations and our access to capital. We also believe this acquisition will further our long-term growth strategy of expanding into post-acute services that complement our core business of operating inpatient rehabilitation hospitals. Specifically, we believe the acquisition of Encompass will enhance our ability to provide a continuum of facility-based and home-based post-acute services to our patients and their families, which we believe will become increasingly important as coordinated care delivery models, such as accountable care organizations ("ACOs") and bundled payment arrangements, become more prevalent. Of note, Encompass has a technology platform designed to manage the entire patient work flow and provide valuable data for health system, payor and ACO partners. Encompass is currently party to one newly-formed ACO serving approximately 20,000 patients and is exploring several other participation opportunities.

Competitive Strengths

As the nation's largest owner and operator of inpatient rehabilitation hospitals and with our experience in and focus on those services, we believe we differentiate ourselves from our competitors based on our broad platform of clinical expertise, the quality of our clinical outcomes, the sustainability of best practices, our financial strength, and the application of rehabilitative technology. With the recent acquisition of Encompass, the fifth largest provider of Medicare-certified skilled home health services, we look forward to combining many of our strengths with those of a proven home health and hospice provider that already offers exceptional patient care in a cost efficient manner in a home-based setting. The competitive strengths of HealthSouth, including Encompass, can also be described in the following ways:

- People. We believe our 29,000 employees, in particular our highly skilled clinical staff, share a steadfast commitment to providing outstanding care to our patients. We also undertake significant efforts to ensure our clinical and support staff receives the education and training necessary to provide the highest quality care in the most cost-effective manner.

- Quality. Our hospitals provide a broad base of clinical experience from which we have developed best practices and protocols. We believe these clinical best practices and protocols help ensure the delivery of consistently high-quality rehabilitative healthcare services across all of our hospitals. We have developed a program called "TeamWorks," which is a series of operations-focused initiatives using identified best practices to reduce inefficiencies and improve performance across a wide spectrum of operational areas. We believe these initiatives have enhanced, and will continue to enhance, patient-employee interactions and coordination of care and communication among the patient, the patient's family, the hospital's treatment team, and payors, which, in turn, improves outcomes and patient satisfaction.

  Additionally, our hospitals participate in The Joint Commission's Disease-Specific Care Certification Program. Under this program, Joint Commission accredited organizations, like our hospitals, may seek certification for chronic diseases or conditions such as brain injury or stroke rehabilitation by complying with Joint Commission standards, effectively using evidence-based, clinical practice guidelines to manage and optimize patient care, and using an organized approach to performance measurement and evaluation of clinical outcomes. Obtaining such certifications demonstrates our commitment to excellence in providing disease-specific care. Currently, 97 of our hospitals hold one or more disease-specific certifications.

  Encompass places a significant emphasis on culture and technology for the purpose of furthering clinical excellence and consistency. Encompass has also developed institutional programs to, among other things, create physician-specific custom treatment protocols and provide care transition from care facilities to home for higher acuity patients. One product of the demonstrated quality of care is the Encompass acute-care readmission rate, which is lower than the industry average for home health.

- Efficiency and Cost Effectiveness. Our size helps us provide facility-based and home-based healthcare services on a cost-effective basis. For example, our inpatient rehabilitation hospitals have historically received, on average, a lower per discharge payment from Medicare than the industry average payment. Specifically, because of our large number of inpatient hospitals, we can utilize proven staffing models and take advantage of certain supply chain efficiencies. In addition, our proprietary management reporting system aggregates data from each of our key business systems into a comprehensive reporting package used by the management teams in our hospitals as well as executive management. This system allows users to analyze data and trends and create custom reports on a timely basis. Likewise, Encompass utilizes Homecare Homebase[SM], an industry-leading information system, to provide home-based care with an emphasis on efficiency and cost effectiveness.

  Encompass also provides HealthSouth with the opportunity to take advantage of the broader focus in healthcare on reducing costs. In an effort to mitigate healthcare costs, third-party payors, including Medicare, have increasingly encouraged the treatment of patients in lower-cost care settings. Additionally, home health and hospice services, which typically have significantly lower-cost structures than facility-based care settings, have increasingly been serving larger populations of higher-acuity patients than in the past. These home-based services provide a cost-effective alternative to facility-based care. Lastly, the combination of home health and hospice with our existing inpatient rehabilitative healthcare services provides us with an increased opportunity to participate in more risk-sharing relationships, such as ACOs and bundled payment arrangements.

- Strong Cash Flow Generation and Balance Sheet. We have a proven track record, even in the challenging regulatory and economic environment of the last several years, of generating strong cash flows from operations that have allowed us to successfully reduce our financial leverage, implement our growth strategy, and make

significant shareholder value-enhancing distributions. As of December 31, 2014, we have a flexible balance sheet with relatively low financial leverage, no significant debt maturities prior to 2019, and ample availability under our revolving credit facility, which along with the cash flows generated from operations should, we believe, provide excellent support for our business strategy.

- Technology. As a market leader in inpatient rehabilitation, we have devoted substantial effort and expertise to leveraging technology to improve patient care and operating efficiencies. Specific rehabilitative technology, such as our internally-developed therapeutic device called the "AutoAmbulator," utilized in our facilities allows us to effectively treat patients with a wide variety of significant physical disabilities or injuries. Our commitment to technology also includes information technology, such as our rehabilitation-specific electronic clinical information system ("CIS") and our internally-developed management reporting system described above. To date, we have installed the CIS in 58 hospitals with another 24 installations scheduled for 2015. We expect to complete installation in our existing hospitals by the end of 2017. We believe the CIS will improve patient care and safety, as well as enhance staff recruitment and retention. Given the increased emphasis on coordination across the patient care spectrum, we also believe the CIS sets the stage for connectivity with referral sources and health information exchanges. Ultimately, we believe the CIS can be a key competitive differentiator and impact patient choice.

  Encompass internally developed, and is now a licensee of, Homecare Homebase, a comprehensive information platform that allows home health providers to process clinical, compliance, and marketing information as well as analyze data and trends for management purposes using custom reports on a timely basis.

Patients and Demographic Trends

Demographic trends, such as population aging, should increase long-term demand for facility-based and home-based post-acute care services. While we treat patients of all ages, most of our patients are 65 and older, and the number of Medicare enrollees is expected to grow approximately 3% per year for the foreseeable future. We believe the demand for facility-based and home-based post-acute care services will continue to increase as the U.S. population ages and life expectancies increase. We believe these factors align with our strengths in, and focus on, post-acute services. In addition, we believe we can address the demand for facility-based and home-based post-acute care services in markets where we currently do not have a presence by constructing or acquiring new hospitals and by acquiring home health and hospice agencies in that extremely fragmented industry.

Strategy

Our 2014 strategy focused on the following priorities:

- continuing to provide high-quality, cost-effective care to patients in our existing markets;
- achieving organic growth at our existing hospitals;
- expanding our services to more patients who require inpatient rehabilitative services by constructing and acquiring new hospitals in new markets;
- continuing our shareholder value-enhancing strategies such as common stock dividends and repurchases of our common stock; and
- positioning the Company for continued success in the evolving healthcare delivery system. This preparation includes continuing the installation of our electronic clinical information system which allows for interfaces with all major acute care electronic medical record systems and health information exchanges, participating in bundling projects and ACOs, and evaluating potential service line expansions via acquisitions.

Total discharges grew 3.5% from 2013 to 2014. Our same-store discharges grew 1.3% during 2014 compared to 2013. We added 51 licensed beds in our existing hospitals in 2014. Our quality and outcome measures, as reported through the Uniform Data System for Medical Rehabilitation (the "UDS"), remained well above the average for hospitals included in the UDS database, and they did so while we continued to increase our market share throughout 2014. Not only did our hospitals treat more patients and enhance outcomes, they did so in a highly cost-effective manner. For additional discussion of the pursuit of our 2014 strategic priorities, including operating results, growth, and shareholder value-enhancing achievements, as well as our 2015 strategy and business outlook, see Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Executive Overview," "Results of Operations," and "Liquidity and Capital Resources."

Employees

As of December 31, 2014 (taking into account the Encompass acquisition), we employed approximately 24,100 individuals, of whom approximately 14,600 were full-time employees, in our inpatient rehabilitation business and approximately 4,900 individuals, of whom approximately 2,900 were full-time employees, in our Encompass Home Health and Hospice business. We are subject to various state and federal laws that regulate wages, hours, benefits, and other terms and conditions relating to employment. Except for approximately 64 employees at one hospital (about 16% of that hospital's workforce), none of our employees are represented by a labor union as of December 31, 2014. Like most healthcare providers, our labor costs are rising faster than the general inflation rate. In some markets, the lack of availability of medical personnel is a significant operating issue facing healthcare providers. To address this challenge, we will continue to focus on maintaining the competitiveness of our compensation and benefit programs and improving our recruitment, retention, and productivity. The shortage of nurses and other medical personnel, including therapists, may, from time to time, require us to increase utilization of more expensive temporary personnel, which we refer to as "contract labor."

Competition

Inpatient Rehabilitation. The inpatient rehabilitation industry is highly fragmented, and we have no single, similar direct competitor. Our inpatient rehabilitation hospitals compete primarily with rehabilitation units, many of which are within acute care hospitals, in the markets we serve. For a list of our markets by state, see the table in Item 2, *Properties.* Smaller privately held companies compete with us primarily in select geographic markets in Texas and the West. In addition, there are public companies that own primarily long-term acute care hospitals but own or operate a small number of inpatient rehabilitation facilities as well, one of which also manages the operations of inpatient rehabilitation facilities as part of its business model. Other providers of post acute-care services may attempt to become competitors in the future. For example, over the past few years, the number of nursing homes marketing themselves as offering certain rehabilitation services has increased even though nursing homes are not required to offer the same level of care, or be licensed, as hospitals. Also, acute care hospitals, including those owned or operated by large public companies, may choose to expand their post-acute rehabilitation services in our markets. The primary competitive factors in any given market include the quality of care and service provided, the treatment outcomes achieved, and the relationship with the acute care hospitals in the market, including physician-owned providers. However, the previously enacted ban on new, or expansion of existing, physician-owned hospitals should limit to some degree that competitive factor going forward unless Congress acts to repeal the ban. See the "Regulation —Relationships with Physicians and Other Providers" section below for further discussion. Additionally, for a discussion regarding the effects of certificate of need requirements on competition in some states, see the "Regulation—Certificates of Need" section below.

Home Health and Hospice. Similarly, the home health and hospice services industry is highly competitive and fragmented. There are currently more than 12,600 home health agencies and approximately 3,900 hospice agencies nationwide certified to participate in Medicare. Encompass is the fifth largest provider of Medicare-certified skilled home health services in the United States. Encompass' primary competition comes from locally owned private home health companies or acute-care hospitals with adjunct home health services and typically varies from market to market. Providers of home health and hospice services include both not-for-profit and for-profit organizations. The primary competitive factors in any given market include the quality of care and service provided, the treatment outcomes achieved, and the relationship with the acute care hospitals, physicians or other referral sources in the market. The ability to work as part of a coordinated care delivery model with other providers is likely to become an increasingly important factor in competition. Competing companies may also offer varying home care services. Home health providers with scale, which include a number of other public companies, may have significant advantages, including professional management, efficient operations, sophisticated information systems, brand recognition, and large referral bases.

Regulatory and Reimbursement Challenges

Healthcare, including the inpatient rehabilitation and home health sectors, has always been a highly regulated industry. Currently, the industry is facing many well-publicized regulatory and reimbursement challenges. The industry is also facing uncertainty associated with the efforts, primarily arising from initiatives included in the Patient Protection and Affordable Care Act (as subsequently amended, the "2010 Healthcare Reform Laws"), to identify and implement workable coordinated care delivery models. Successful healthcare providers are those who provide high-quality, cost-effective care and have the ability to adjust to changes in the regulatory and operating environments. We believe we have the necessary capabilities — scale, infrastructure, balance sheet, and management — to adapt to and succeed in a highly regulated industry, and we have a proven track record of doing so. For more in-depth discussion of the primary challenges and risks related to our business, particularly the changes in Medicare reimbursement (including sequestration), increased federal compliance and enforcement burdens, and changes to our operating environment resulting from healthcare reform, see "Regulation" below in this section as well as

Item 1A, *Risk Factors,* and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations,* "Executive Overview—Key Challenges."

Sources of Revenues

We receive payment for patient care services from the federal government (primarily under the Medicare program), managed care plans and private insurers, and, to a considerably lesser degree, state governments (under their respective Medicaid or similar programs) and directly from patients. Revenues and receivables from Medicare are significant to our operations. In addition, we receive relatively small payments for non-patient care activities from various sources. The following table identifies the sources and relative mix of our revenues for the periods stated and does not include Encompass revenues of which Medicare historically represents a significant portion:

	For the Year Ended December 31,		
	2014	2013	2012
Medicare	74.1%	74.5%	73.4%
Medicaid	1.8%	1.2%	1.2%
Workers' compensation	1.2%	1.2%	1.5%
Managed care and other discount plans, including Medicare Advantage	18.6%	18.5%	19.3%
Other third-party payors	1.8%	1.8%	1.8%
Patients	1.0%	1.1%	1.3%
Other income	1.5%	1.7%	1.5%
Total	100.0%	100.0%	100.0%

Our hospitals offer discounts from established charges to certain group purchasers of healthcare services that are included in "Managed care and other discount plans" in the table above, including private insurance companies, employers, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other managed care plans. Medicare, through its Medicare Advantage program, offers Medicare-eligible individuals an opportunity to participate in a managed care plan. Revenues from Medicare and Medicare Advantage represent approximately 82% of total revenues.

Patients are generally not responsible for the difference between established gross charges and amounts reimbursed for such services under Medicare, Medicaid, and other private insurance plans, HMOs, or PPOs but are responsible to the extent of any exclusions, deductibles, copayments, or coinsurance features of their coverage. Collection of amounts due from individuals is typically more difficult than from governmental or third-party payors. The amount of these exclusions, deductibles, copayments, and coinsurance has been increasing each year but is not material to our business or results of operations.

Medicare Reimbursement

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons aged 65 and over, some disabled persons, and persons with end-stage renal disease. Medicare, through statutes and regulations, establishes reimbursement methodologies and rates for various types of healthcare facilities and services. Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency that advises Congress on issues affecting Medicare, makes payment policy recommendations to Congress for a variety of Medicare payment systems including, among others, the inpatient rehabilitation facility ("IRF") prospective payment system (the "IRF-PPS"), the home health prospective payment system ("HH-PPS") and the hospice prospective payment system. Congress is not obligated to adopt MedPAC recommendations, and, based on outcomes in previous years, there can be no assurance Congress will adopt MedPAC's recommendations in a given year. For example, in recent years, Congress has not adopted any of the recommendations on the annual market basket update to Medicare payment rates under the IRF-PPS, which updates are discussed in greater detail below. However, MedPAC's recommendations have, and may in the future, become the basis for subsequent legislative or regulatory action.

The Medicare statutes and regulations are subject to change from time to time. For example, in March 2010, President Obama signed the 2010 Healthcare Reform Laws. With respect to Medicare reimbursement, the 2010 Healthcare Reform Laws provided for certain reductions to healthcare providers' annual market basket updates. In August 2011, President Obama signed into law the Budget Control Act of 2011, as amended by the American Taxpayer Relief Act of 2012, the Bipartisan Budget Act of 2013, and the Protecting Access to Medicare Act of 2014, that provided for an automatic 2% reduction, or "sequestration," of Medicare program payments for all healthcare providers. Sequestration took effect April 1, 2013 and will continue through 2024 unless Congress and the President take further action. Additionally, concerns held by federal policymakers about the

federal deficit and national debt levels could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, or both, in 2015 and beyond.

From time to time, Medicare reimbursement methodologies and rates can be further modified by the United States Department of Health and Human Services ("HHS"), Centers for Medicare & Medicaid Services ("CMS"). In some instances, these modifications can have a substantial impact on existing healthcare providers. In accordance with Medicare laws and statutes, CMS makes annual adjustments to Medicare payment rates in many prospective payment systems, including the IRF-PPS and HH-PPS, by what is commonly known as a "market basket update." CMS may take other regulatory action affecting rates as well. For example, under the 2010 Healthcare Reform Laws, CMS requires IRFs to submit data on certain quality of care measures for the IRF Quality Reporting Program. A facility's failure to submit the required quality data results in a two percentage point reduction to that facility's annual market basket increase factor for payments made for discharges in the subsequent Medicare fiscal year. Hospitals began submitting quality data to CMS in October 2012. All of our hospitals met the reporting deadlines occurring on or before December 31, 2013 resulting in no corresponding reimbursement reductions for fiscal year 2015. In addition, CMS will begin conducting validation audits to ensure the completeness and accuracy of the quality data submitted, the results of which may impact payment updates beginning in fiscal year 2016. A facility's failure to meet the required accuracy benchmark also will result in a two percentage point reduction to that facility's annual market basket increase factor for payments made for discharges in the subsequent Medicare fiscal year. Similarly, home health and hospice agencies are also required to submit quality data to CMS each year, and the failure to do so in accordance with the rules will result in a two percentage point reduction in their market basket update.

CMS has also adopted final rules that require healthcare providers to update and supplement diagnosis and procedure codes to the International Classification of Diseases 10th Edition ("ICD-10"), effective October 1, 2015. We are currently modifying our systems to accommodate the adoption of ICD-10. We expect to be in compliance on a timely basis. Although this adoption process will result in system conversion expenses and may result in some disruptions to the billing process and delays in the receipt of some payments, we do not believe there will be a material impact on our business. We will continue to monitor this implementation carefully.

We cannot predict the adjustments to Medicare payment rates Congress or CMS may make in the future. Congress, MedPAC, and CMS will continue to address reimbursement rates for a variety of healthcare settings. Any additional downward adjustment to rates for the types of facilities we operate and services we provide could have a material adverse effect on our business, financial position, results of operations, and cash flows. For additional discussion of the risks associated with our concentration of revenues from the federal government or with potential changes to the statutes or regulations governing Medicare reimbursement, see Item 1A, *Risk Factors.*

A basic summary of current Medicare reimbursement in our primary service areas follows:

Inpatient Rehabilitation. As discussed above, our hospitals receive fixed payment reimbursement amounts per discharge under IRF-PPS based on certain rehabilitation impairment categories established by the United States Department of Health and Human Services ("HHS"). In order to qualify for reimbursement under IRF-PPS, our hospitals must comply with various Medicare rules and regulations including documentation and coverage requirements, or specifications as to what conditions must be met to qualify for reimbursement. These requirements relate to, among other things, pre-admission screening, post-admission evaluations, and individual treatment planning that all delineate the role of physicians in ordering and overseeing patient care. With IRF-PPS, our hospitals retain the difference, if any, between the fixed payment from Medicare and their operating costs. Thus, our hospitals benefit from being cost-effective providers.

Under IRF-PPS, CMS is required to adjust the payment rates based on a market basket index, known as the rehabilitation, psychiatric, and long-term care hospital market basket. The market basket update is designed to reflect changes over time in the prices of a mix of goods and services provided by rehabilitation hospitals and hospital-based inpatient rehabilitation units. The market basket uses data furnished by the Bureau of Labor Statistics for price proxy purposes, primarily in three categories: Producer Price Indexes, Consumer Price Indexes, and Employment Cost Indexes.

Over the last several years, changes in regulations governing inpatient rehabilitation reimbursement have created challenges for inpatient rehabilitation providers. Many of these changes have resulted in limitations on, and in some cases, reductions in, the levels of payments to healthcare providers. For example, on May 7, 2004, CMS issued a final rule, known as the "75% Rule," stipulating that to qualify as an inpatient rehabilitation hospital under the Medicare program a facility must show that a certain percentage of its patients are treated for at least one of a specified and limited list of medical conditions. Under the 75% Rule, any inpatient rehabilitation hospital that failed to meet its requirements would be subject to prospective reclassification as an acute care hospital, with lower acute care payment rates for rehabilitative services. On December 29, 2007, the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (the "2007 Medicare Act") was signed, setting the compliance threshold at 60% instead of 75% and allowing hospitals to continue using a

patient's secondary medical conditions, or "comorbidities," to determine whether a patient qualifies for inpatient rehabilitative care under the rule. The long-term impact of the freeze at the 60% compliance threshold is positive because it allowed patient volumes to stabilize. In another example, the 2007 Medicare Act included an elimination of the IRF-PPS market basket adjustment for the period from April 1, 2008 through September 30, 2009 causing a reduction in the pricing of services eligible for Medicare reimbursement to a pricing level that existed in the third quarter of 2007, or a Medicare pricing "roll-back," which resulted in a decrease in actual reimbursement dollars per discharge despite increases in costs.

On July 31, 2013, CMS released its notice of final rulemaking for the fiscal year 2014 IRF-PPS. This rule was effective for Medicare discharges between October 1, 2013 and September 30, 2014. The pricing changes in this rule included a 2.6% market basket update that was reduced by 0.3% to 2.3% under the requirements of the 2010 Healthcare Reform Laws, as well as other pricing changes that impact our hospital-by-hospital base rate for Medicare reimbursement. The 2010 Healthcare Reform Laws also require the market basket update to be reduced by a productivity adjustment on an annual basis. The productivity adjustments equal the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. The productivity adjustment effective October 1, 2013 decreased the market basket update by 50 basis points.

On July 31, 2014, CMS released its notice of final rulemaking for fiscal year 2015 IRF-PPS (the "2015 Rule"). The 2015 Rule will implement a net 2.2% market basket increase effective for discharges between October 1, 2014 and September 30, 2015, calculated as follows:

Market basket update	2.9%
Healthcare reform reduction	20 basis points
Productivity adjustment reduction	50 basis points

The 2015 Rule also includes other pricing changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, freezing the IRF-PPS facility-level rural adjustment factor, low-income patient factor, teaching status adjustment factor, and updates to the outlier fixed loss threshold. Based on our analysis which utilizes, among other things, the acuity of our patients over the 12-month period prior to the rule's release and incorporates other adjustments included in the 2015 Rule, we believe the 2015 Rule will result in a net increase to our Medicare payment rates of approximately 2.3% effective October 1, 2014 before sequestration.

Although reductions or changes in reimbursement from governmental or third-party payors and regulatory changes affecting our business represent one of the most significant challenges to our business, our operations are also affected by coverage rules and determinations. Medicare providers like us can be negatively affected by the adoption of coverage policies, either at the national or local level, that determine whether an item or service is covered and under what clinical circumstances it is considered to be reasonable and necessary. Current CMS coverage rules require inpatient rehabilitation services to be ordered by a qualified rehabilitation physician and be coordinated by an interdisciplinary team. The interdisciplinary team must meet weekly to review patient status and make any needed adjustments to the individualized plan of care. Qualified personnel must provide required rehabilitation nursing, physical therapy, occupational therapy, speech-language pathology, social services, psychological services, and prosthetic and orthotic services. For individual claims, Medicare contractors make coverage determinations regarding medical necessity which can represent more restrictive interpretations of the CMS coverage rules. We cannot predict how future CMS coverage rule interpretations or any new local coverage determinations will affect us.

Pursuant to legislative directives and authorizations from Congress, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. These audits are in addition to those conducted by existing Medicare Administrative Contractors ("MACs"). Some contractors are paid a percentage of the overpayments recovered. One type of audit contractor, the Recovery Audit Contractors ("RACs"), began post-payment audit processes in late 2009 for providers in general. The RACs receive claims data directly from MACs on a monthly or quarterly basis and are authorized to review claims up to three years from the date a claim was paid. The 2010 Healthcare Reform Laws extended the RAC program to Medicare, Parts C and D, and Medicaid. RAC audits initially focused on coding errors. CMS subsequently expanded the program to medical necessity reviews for IRFs.

In connection with CMS approved and announced RAC audits related to IRFs, we have received requests to review certain patient files for discharges occurring from 2010 to 2014. To date, the Medicare payments that are subject to these audit requests represent less than 1% of our Medicare patient discharges during those years, and not all of these patient files requests have resulted in payment denial determinations by the RACs.

These post-payment RAC audits are focused on medical necessity requirements for admission to IRFs rather than targeting a specific diagnosis code as in previous pre-payment audits. Medical necessity is a subjective assessment by an

independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting. Because we have confidence in the medical judgment of both the referring and the admitting physicians who assess the treatment needs of our patients, we have appealed substantially all RAC denials arising from these audits.

The contracts awarded to RACs by CMS were set to expire in February 2014, but they have been extended and modified pending finalization of new contracts. In late February 2014, CMS announced it would pause the operations of the current RACs until new contracts are awarded, meaning that hospitals would not receive any new requests from RACs until that time. Legal challenges to the contract award process have delayed finalizing the new contracts longer than expected, and as a result, CMS modified the existing RAC contracts to allow some RAC reviews to be restarted on a limited basis. Additionally, on December 30, 2014, CMS announced the beginning of a new contract for the RAC assigned to audit payments for home health and hospice services, which has subsequently been delayed by another challenge. Once new contracts are in place, whether for IRFs or home health and hospice agencies, the associated RACs will be able to audit claims for dates of service during the time period covered by the pause in RAC operations. We cannot predict when the challenges to the new contracts will be resolved or when CMS will otherwise finalize the new RAC contracts.

While we make provisions for these claims based on our historical experience and success rates in the claim adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs, we cannot provide assurance as to our future success in the resolution of these and future disputes, nor can we predict or estimate the scope or number of denials that ultimately may be received. Due to additional delays announced by CMS in the related adjudication process, we believe the resolution of any claims that are subsequently denied as a result of these RAC audits could take in excess of two years.

CMS has also established contractors known as the Zone Program Integrity Contractors ("ZPICs"). These contractors are successors to the Program Safeguard Contractors and conduct audits with a focus on potential fraud and abuse issues. Like the RACs, the ZPICs conduct audits and have the ability to refer matters to the United States Department of Health and Human Services Office of Inspector General (the "HHS-OIG") or the United States Department of Justice. Unlike RACs, however, ZPICs do not receive a specific financial incentive based on the amount of the error.

As a matter of course, we undertake significant efforts through training and education to ensure compliance with coding and medical necessity coverage rules. However, despite our belief that our coding and assessment of patients are accurate, audits may lead to assertions that we have been underpaid or overpaid by Medicare or submitted improper claims in some instances, require us to incur additional costs to respond to requests for records and defend the validity of payments and claims, and ultimately require us to refund any amounts determined to have been overpaid. We cannot predict when or how these audit programs will affect us. For additional discussion of these audits and the risks associated with them, see Item 1A, *Risk Factors*, and Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, "Executive Overview—Key Challenges."

Home Health. Encompass Home Health and Hospice has historically derived a substantial portion of revenue from Medicare. For the year ended December 31, 2014, approximately 83% of Encompass' total revenues for these services were from Medicare (excluding Medicare Advantage). Encompass' pediatric services, which represent approximately 8% of Encompass' total revenues for the year ended December 31, 2014, are a part of its home health business but are reimbursed primarily through Medicaid.

Medicare pays home health benefits for patients discharged from a hospital or patients otherwise suffering from chronic conditions that require ongoing but intermittent skilled care. As a condition of participation under Medicare, patients must be homebound (meaning unable to leave their home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services, or have a continuing need for occupational therapy, and receive treatment under a plan of care established and periodically reviewed by a physician. The 2010 Healthcare Reform Laws mandate that, prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she or a qualifying nurse practitioner has had a face-to-face encounter with the patient. Medicare pays home health providers under the HH-PPS for each 60-day period of care for each patient. Payments are adjusted based on each patient's condition and clinical treatment. This is referred to as the case-mix adjustment. In addition to the case-mix adjustment, payments for periods of care may be adjusted for other reasons, including unusually large (outlier) costs, low-utilization patients that require four or fewer visits, and geographic differences in wages. Payments are also made for nonroutine medical supplies that are used in treatment. Home health providers receive either 50% or 60% of the estimated base payment for the full 60 days for each patient upon submission of the initial claim. The estimate is based on the patient's condition and treatment needs. The provider receives the remaining portion of the payment after the 60-day treatment period, subject to any applicable adjustments. If a patient remains eligible for care after that period, a new treatment period may begin. There are currently no limits to the number of home health treatment periods an eligible Medicare patient may receive.

On October 30, 2014, CMS released the calendar year 2015 HH-PPS final rule. CMS estimates the rule will cut Medicare payments to home health agencies by 0.3% in 2015. Specifically, while the rule provides for a market basket update of 2.6%, that update is offset by a 2.4% rebasing adjustment reduction (the second year of a four-year phase-in) and a productivity adjustment reduction of 50 basis points. We believe this final rule will result in a net decrease to Encompass' Medicare payment rates of approximately 1.3% in calendar year 2015 before sequestration.

The final rule also addresses a number of policy proposals. Notably, CMS is modifying the home health face-to-face encounter documentation requirements, including eliminating the narrative as part of the certification of eligibility and providing more flexibility in procedures for obtaining documentation supporting patient eligibility. CMS also discusses comments it received on a potential home health agency value-based purchasing model, under which CMS would test whether payment incentives would lead to higher quality of care for beneficiaries. CMS is considering testing such a model beginning in 2016. Additional details will be provided in future rulemaking.

Hospice. Medicare pays hospice benefits for patients with life expectancies of six months or less, as documented by the patient's physician(s). Under Medicare rules, patients seeking hospice benefits must agree to forgo curative treatment for their terminal medical conditions. For each day a patient elects hospice benefits, Medicare pays an adjusted daily rate based on patient location, and payments represent a prospective per diem amount tied to one of four different categories or levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care. Medicare hospice reimbursements to each provider are also subject to two annual caps, one limiting total hospice payments based on the average annual payment per beneficiary and another limiting payments based on the number of days of inpatient care billed by the hospice provider. There are currently no limits to the number of hospice benefit periods an eligible Medicare patient may receive, and a patient may revoke the benefit at any time.

Outpatient. Our outpatient services are primarily reimbursed under Medicare's physician fee schedule. By statute, the physician fee schedule is subject to annual automatic adjustment by a sustainable growth rate formula that has resulted in reductions in reimbursement rates every year since 2002. However, in each instance, Congress has acted to suspend or postpone the effectiveness of these automatic reimbursement reductions. For example, the Protecting Access to Medicare Act of 2014 postponed the statutory reduction in the Medicare physician fee schedule payment rates through March 31, 2015. Under the CMS final notice of rulemaking for the physician fee schedule for calendar year 2015, released on October 31, 2014, a statutory reduction of approximately 21% will go into effect on April 1, 2015. If Congress does not again extend relief as it has done since 2002 or permanently modify the sustainable growth rate formula by April 1, 2015, payment levels for outpatient services under the physician fee schedule will be reduced at that point. We currently estimate that a reduction of that size, before taking into account our efforts to mitigate these changes, which would likely include closure of additional outpatient satellite clinics, would result in a net decrease in our *Net operating revenues* of approximately $2.9 million annually. However, we cannot predict what action, if any, Congress will take on the physician fee schedule and other reimbursement matters affecting our outpatient services or what future rule changes CMS will implement.

For additional discussion of matters and risks related to reimbursement, see Item 1A, *Risk Factors*.

Medicaid Reimbursement

Medicaid is a jointly administered and funded federal and state program that provides hospital and medical benefits to qualifying individuals who are deemed unable to afford healthcare. As the Medicaid program is administered by the individual states under the oversight of CMS in accordance with certain regulatory and statutory guidelines, there are substantial differences in reimbursement methodologies and coverage policies from state to state. Many states have experienced shortfalls in their Medicaid budgets and are implementing significant cuts in Medicaid reimbursement rates. Additionally, certain states control Medicaid expenditures through restricting or eliminating coverage of certain services. Continuing downward pressure on Medicaid payment rates could cause a decline in that portion of our *Net operating revenues*. However, for the year ended December 31, 2014, Medicaid payments represented only 1.8% of our consolidated *Net operating revenues*, and Encompass' Medicaid billings are not expected to have a material impact on that percentage in 2015. Although the 2010 Healthcare Reform Laws contain provisions intended to expand Medicaid coverage, parts of which were invalidated by the U.S. Supreme Court, we do not believe the expanded coverage will have a material impact on our consolidated *Net operating revenues* given our current patient mix, including that of Encompass.

Managed Care and Other Discount Plans

All of our hospitals offer discounts from established charges to certain large group purchasers of healthcare services, including Medicare Advantage, managed care plans, private insurance companies, and third-party administrators. Managed care contracts typically have terms between one and three years, although we have a number of managed care contracts that automatically renew each year (with pre-defined rate increases between two and four percent) unless a party elects to terminate

the contract. While our average rate increase on the contracts renegotiated in 2014 was approximately 3%, we cannot provide any assurance we will continue to receive increases in the future. Our managed care staff focuses on establishing and re-negotiating contracts that provide equitable reimbursement for the services provided.

For the year ended December 31, 2014, managed care contracts, including Medicare Advantage, represented approximately 10% of Encompass' revenues.

Cost Reports

Because of our participation in Medicare, Medicaid, and certain Blue Cross and Blue Shield plans, we are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require the submission of annual cost reports covering the revenue, costs, and expenses associated with the services provided by inpatient hospital, home health, and hospice providers to Medicare beneficiaries and Medicaid recipients. These annual cost reports are subject to routine audits which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. These audits are used for determining if any under- or over-payments were made to these programs and to set payment levels for future years. Medicare also makes retroactive adjustments to payments for certain low-income patients after comparing subsequently published statistical data from CMS to the cost report data. We cannot predict what retroactive adjustments, if any, will be made, but we do not anticipate such adjustments would have a material impact on our financial position, results of operations, and cash flows.

Regulation

The healthcare industry is subject to significant federal, state, and local regulation that affects our business activities by controlling the reimbursement we receive for services provided, requiring licensure or certification of our operations, regulating our relationships with physicians and other referral sources, regulating the use of our properties, and controlling our growth. We are also subject to the broader federal and state regulations that prohibit fraud and abuse in the delivery of healthcare services. As a healthcare provider, we are subject to periodic audits, examinations and investigations conducted by, or at the direction of, government investigative and oversight agencies. Violations of the applicable federal and state healthcare regulations can result in a provider's exclusion from participation in government reimbursement programs and in substantial civil and criminal penalties.

We undertake significant effort and expense to provide the medical, nursing, therapy, and ancillary services required to comply with local, state, and federal regulations, as well as, for most facilities, accreditation standards of The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations) and, for some facilities, the Commission on Accreditation of Rehabilitation Facilities.

We maintain a comprehensive compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. The program is intended to monitor and raise awareness of various regulatory issues among employees and to emphasize the importance of complying with governmental laws and regulations. As part of the compliance program, we provide annual compliance training to our employees and encourage all employees to report any violations to their supervisor or through a toll-free telephone hotline.

Licensure and Certification

Healthcare facility construction and operation are subject to numerous federal, state, and local regulations relating to, among other things, the adequacy of medical care, equipment, personnel, operating policies and procedures, acquisition and dispensing of pharmaceuticals and controlled substances, infection control, maintenance of adequate records and patient privacy, fire prevention, and compliance with building codes and environmental protection laws. Our hospitals are subject to periodic inspection and other reviews by governmental and non-governmental certification authorities to ensure continued compliance with the various standards necessary for facility licensure. All of our inpatient hospitals are currently required to be licensed.

In addition, hospitals must be certified by CMS to participate in the Medicare program and generally must be certified by Medicaid state agencies to participate in Medicaid programs. Once certified by Medicare, hospitals undergo periodic on-site surveys and revalidations in order to maintain their certification. All of our inpatient hospitals participate in the Medicare program.

Encompass locations are each licensed under applicable law, certified by CMS for participation in the Medicare program, and generally certified by the applicable state Medicaid agencies to participate in those programs.

Failure to comply with applicable certification requirements may make our hospitals and agencies, as the case may be, ineligible for Medicare or Medicaid reimbursement. In addition, Medicare or Medicaid may seek retroactive reimbursement from noncompliant facilities or otherwise impose sanctions on noncompliant facilities. Non-governmental payors often have the right to terminate provider contracts if a facility loses its Medicare or Medicaid certification.

The 2010 Healthcare Reform Laws added new screening requirements and associated fees for all Medicare providers. The screening must include a licensure check and may include other procedures such as fingerprinting, criminal background checks, unscheduled and unannounced site visits, database checks, and other screening procedures prescribed by CMS.

We have developed operational systems to oversee compliance with the various standards and requirements of the Medicare program and have established ongoing quality assurance activities; however, given the complex nature of governmental healthcare regulations, there can be no assurance Medicare, Medicaid, or other regulatory authorities will not allege instances of noncompliance. A determination by a regulatory authority that a facility is not in compliance with applicable requirements could also lead to the assessment of fines or other penalties, loss of licensure, and the imposition of requirements that an offending facility takes corrective action.

Certificates of Need

In some states and U.S. territories where we operate, the construction or expansion of facilities, the acquisition of existing facilities, or the introduction of new beds or services may be subject to review by and prior approval of state regulatory bodies under a "certificate of need," or "CON," law. As of December 31, 2014, approximately 51% of our licensed beds are located in states or U.S. territories that have CON laws. CON laws also apply to home health and hospice services in certain states. However, Encompass does not currently operate in any states requiring a CON to provide home health or hospice services. CON laws often require a reviewing agency to determine the public need for additional or expanded healthcare facilities and services. These laws generally require approvals for capital expenditures involving inpatient rehabilitation hospitals, if such capital expenditures exceed certain thresholds. In addition, CON laws in some states require us to abide by certain charity care commitments as a condition for approving a CON. Any time a CON is required, we must obtain it before acquiring, opening, reclassifying, or expanding a healthcare facility or starting a new healthcare program.

We potentially face opposition any time we initiate a CON project or seek to acquire an existing facility or CON. This opposition may arise either from competing national or regional companies or from local hospitals or other providers which file competing applications or oppose the proposed CON project. Opposition to our applications may delay or prevent our future addition of beds or hospitals in given markets or increase our costs in seeking those additions. The necessity for these approvals serves as a barrier to entry and has the potential to limit competition, including in markets where we hold a CON and a competitor is seeking an approval. We have generally been successful in obtaining CONs or similar approvals when required, although there can be no assurance we will achieve similar success in the future, and the likelihood of success varies by state.

False Claims

The federal False Claims Act prohibits the knowing presentation of a false claim to the United States government and provides for penalties equal to three times the actual amount of any overpayments plus up to $11,000 per claim. In addition, the False Claims Act allows private persons, known as "relators," to file complaints under seal and provides a period of time for the government to investigate such complaints and determine whether to intervene in them and take over the handling of all or part of such complaints. Because we perform thousands of similar procedures a year for which we are reimbursed by Medicare and other federal payors and there is a relatively long statute of limitations, a billing error or cost reporting error could result in significant civil or criminal penalties under the False Claims Act. Many states have also adopted similar laws relating to state government payments for healthcare services. The 2010 Healthcare Reform Laws amended the federal False Claims Act to expand the definition of false claim, to make it easier for the government to initiate and conduct investigations, to enhance the monetary reward to relators where prosecutions are ultimately successful, and to extend the statute of limitations on claims by the government. The federal government has become increasingly aggressive in asserting that incidents of erroneous billing or record keeping represent a violation of the False Claims Act. For additional discussion, see Item 1A, *Risk Factors*, and Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Relationships with Physicians and Other Providers

Anti-Kickback Law. Various state and federal laws regulate relationships between providers of healthcare services, including management or service contracts and investment relationships. Among the most important of these restrictions is a federal law prohibiting the offer, payment, solicitation, or receipt of remuneration by individuals or entities to induce referrals of patients for services reimbursed under the Medicare or Medicaid programs (the "Anti-Kickback Law"). The 2010 Healthcare Reform Laws amended the federal Anti-Kickback Law to provide that proving violations of this law does not require proving

actual knowledge or specific intent to commit a violation. Another amendment made it clear that Anti-Kickback Law violations can be the basis for claims under the False Claims Act. These changes and those described above related to the False Claims Act, when combined with other recent federal initiatives, are likely to increase investigation and enforcement efforts in the healthcare industry generally. In addition to standard federal criminal and civil sanctions, including imprisonment and penalties of up to $50,000 for each violation plus tripled damages for improper claims, violators of the Anti-Kickback Law may be subject to exclusion from the Medicare and/or Medicaid programs. In 1991, the HHS-OIG issued regulations describing compensation arrangements that are not viewed as illegal remuneration under the Anti-Kickback Law. Those regulations provide for certain safe harbors for identified types of compensation arrangements that, if fully complied with, assure participants in the particular arrangement that the HHS-OIG will not treat that participation as a criminal offense under the Anti-Kickback Law or as the basis for an exclusion from the Medicare and Medicaid programs or the imposition of civil sanctions. Failure to fall within a safe harbor does not constitute a violation of the Anti-Kickback Law, but the HHS-OIG has indicated failure to fall within a safe harbor may subject an arrangement to increased scrutiny. A violation of the Anti-Kickback Law by us or one or more of our partnerships could have a material adverse effect upon our business, financial position, results of operations, or cash flows. Even the assertion of a violation could have an adverse effect upon our stock price or reputation.

Some of our rehabilitation hospitals are owned through joint ventures with institutional healthcare providers that may be in a position to make or influence referrals to our hospitals. In addition, we have a number of relationships with physicians and other healthcare providers, including management or service contracts. Some of these investment relationships and contractual relationships may not meet all of the regulatory requirements to fall within the protection offered by a relevant safe harbor. Despite our compliance and monitoring efforts, there can be no assurance violations of the Anti-Kickback Law will not be asserted in the future, nor can there be any assurance our defense against any such assertion would be successful.

For example, we have entered into agreements to manage our hospitals that are owned by partnerships. Most of these agreements incorporate a percentage-based management fee. Although there is a safe harbor for personal services and management contracts, this safe harbor requires, among other things, the aggregate compensation paid to the manager over the term of the agreement be set in advance. Because our management fee may be based on a percentage of revenues, the fee arrangement may not meet this requirement. However, we believe our management arrangements satisfy the other requirements of the safe harbor for personal services and management contracts and comply with the Anti-Kickback Law.

Physician Self-Referral Law. The federal law commonly known as the "Stark law" and CMS regulations promulgated under the Stark law prohibit physicians from making referrals for "designated health services" including inpatient and outpatient hospital services, physical therapy, occupational therapy, radiology services, and home health services, to an entity in which the physician (or an immediate family member) has an investment interest or other financial relationship, subject to certain exceptions. The Stark law also prohibits those entities from filing claims or billing Medicare for those referred services. Violators of the Stark law and regulations may be subject to recoupments, civil monetary sanctions (up to $15,000 for each violation and assessments up to three times the amount claimed for each prohibited service) and exclusion from any federal, state, or other governmental healthcare programs. The statute also provides a penalty of up to $100,000 for a circumvention scheme. There are statutory exceptions to the Stark law for many of the customary financial arrangements between physicians and providers, including personal services contracts and leases. However, in order to be afforded protection by a Stark law exception, the financial arrangement must comply with every requirement of the applicable exception.

Under the 2010 Healthcare Reform Laws, the exception to the Stark law that currently permits physicians to refer patients to hospitals in which they have an investment or ownership interest has been dramatically limited by providing that only physician-owned hospitals with a provider agreement in place on December 31, 2010 are exempt from the general ban on self-referral. Existing physician-owned hospitals are prohibited from increasing the physician ownership percentage in the hospital after March 23, 2010. Additionally, physician-owned hospitals are prohibited from increasing the number of licensed beds after March 23, 2010, except when certain market and regulatory approval conditions are met. Currently, we have no hospitals that would be considered physician-owned under this law.

CMS has issued several phases of final regulations implementing the Stark law. While these regulations help clarify the requirements of the exceptions to the Stark law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. Because many of these laws and their implementing regulations are relatively new, we do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. We attempt to structure our relationships to meet an exception to the Stark law, but the regulations implementing the exceptions are detailed and complex. Accordingly, we cannot assure that every relationship complies fully with the Stark law.

Additionally, no assurances can be given that any agency charged with enforcement of the Stark law and regulations might not assert a violation under the Stark law, nor can there be any assurance our defense against any such assertion would be successful or that new federal or state laws governing physician relationships, or new interpretations of existing laws governing such relationships, might not adversely affect relationships we have established with physicians or result in the imposition of

penalties on us or on particular HealthSouth hospitals or another of our providers. Even the assertion of a violation could have an adverse effect upon our stock price or reputation.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, commonly known as "HIPAA," broadened the scope of certain fraud and abuse laws by adding several criminal provisions for healthcare fraud offenses that apply to all health benefit programs. HIPAA also added a prohibition against incentives intended to influence decisions by Medicare or Medicaid beneficiaries as to the provider from which they will receive services. In addition, HIPAA created new enforcement mechanisms to combat fraud and abuse, including the Medicare Integrity Program, and an incentive program under which individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds. Penalties for violations of HIPAA include civil and criminal monetary penalties.

HIPAA and related HHS regulations contain certain administrative simplification provisions that require the use of uniform electronic data transmission standards for certain healthcare claims and payment transactions submitted or received electronically. HIPAA regulations also regulate the use and disclosure of individually identifiable health-related information, whether communicated electronically, on paper, or orally. The regulations provide patients with significant rights related to understanding and controlling how their health information is used or disclosed and require healthcare providers to implement administrative, physical, and technical practices to protect the security of individually identifiable health information that is maintained or transmitted electronically.

With the enactment of the Health Information Technology for Economic and Clinical Health ("HITECH") Act as part of the American Recovery and Reinvestment Act of 2009, the privacy and security requirements of HIPAA have been modified and expanded. The HITECH Act applies certain of the HIPAA privacy and security requirements directly to business associates of covered entities. The modifications to existing HIPAA requirements include: expanded accounting requirements for electronic health records, tighter restrictions on marketing and fundraising, and heightened penalties and enforcement associated with noncompliance. Significantly, the HITECH Act also establishes new mandatory federal requirements for notification of breaches of security involving protected health information. HHS is responsible for enforcing the requirement that covered entities notify any individual whose protected health information has been improperly acquired, accessed, used, or disclosed. In certain cases, notice of a breach is required to be made to HHS and media outlets. The heightened penalties for noncompliance range from $100 to $50,000 per violation for most violations. In the event of violations due to willful neglect that are not corrected within 30 days, penalties start at $50,000 per violation and are not subject to a per violation statutory maximum. All penalties are subject to a $1,500,000 cap for multiple identical violations in a single calendar year. Willful neglect could include the failure to conduct a security risk assessment or adequately implement HIPAA compliance policies.

On January 17, 2013, the HHS Office for Civil Rights issued a final rule, with a compliance date of September 23, 2013, to implement the HITECH Act and make other modifications to the HIPAA and HITECH regulations. This rule expanded the potential liability for a breach involving protected health information to cover some instances where a subcontractor is responsible for the breaches and that individual or entity was acting within the scope of delegated authority under the related contract or engagement. The final rule generally defines "breach" to mean the acquisition, access, use or disclosure of protected health information in a manner not permitted by the HIPAA privacy standards, which compromises the security or privacy of protected health information. Under the final rule, improper acquisition, access, use, or disclosure is presumed to be a reportable breach, unless the potentially breaching party can demonstrate a low probability that protected health information has been compromised. On the whole, it appears the changes to the breach reporting rules could increase breach reporting in the healthcare industry.

In addition, there are numerous legislative and regulatory initiatives at the federal and state levels addressing patient privacy concerns. Healthcare providers will continue to remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. Any actual or perceived violation of privacy-related laws and regulations, including HIPAA and the HITECH Act, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Available Information

Our website address is www.healthsouth.com. We make available through our website the following documents, free of charge: our annual reports (Form 10-K), our quarterly reports (Form 10-Q), our current reports (Form 8-K), and any amendments to those reports promptly after we electronically file such material with, or furnish it to, the United States Securities and Exchange Commission. In addition to the information that is available on our website, the reader may review and copy any materials we file with or furnish to the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Washington, D.C. 20549. The reader may obtain information on the operation of the Public Reference Room by calling the

SEC at 1-800-SEC-0330. The SEC also maintains a website, www.sec.gov, which includes reports, proxy and information statements, and other information regarding us and other issuers that file electronically with the SEC.

Item 1A. Risk Factors

Our business, operations, and financial position are subject to various risks. Some of these risks are described below, and the reader should take such risks into account in evaluating HealthSouth or any investment decision involving HealthSouth. This section does not describe all risks that may be applicable to us, our industry, or our business, and it is intended only as a summary of certain material risk factors. More detailed information concerning other risk factors as well as those described below is contained in other sections of this annual report.

Risks Related to Our Business

Reductions or changes in reimbursement from government or third-party payors and other legislative and regulatory changes affecting our industry could adversely affect our operating results.

We derive a substantial portion of our *Net operating revenues* from the Medicare program. See Item 1, *Business*, "Sources of Revenues," for a table identifying the sources and relative payor mix of our revenues. Historically, Congress and some state legislatures have periodically proposed significant changes in regulations governing the healthcare system. Many of these changes have resulted in limitations on the increases in and, in some cases, significant roll-backs or reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. There can be no assurance that future governmental initiatives will not result in pricing roll-backs or freezes or reimbursement reductions.

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (as subsequently amended, the "2010 Healthcare Reform Laws"). Many provisions within the 2010 Healthcare Reform Laws have impacted or could in the future impact our business, including: (1) reducing annual market basket updates to providers, which include annual productivity adjustment reductions; (2) the possible combining, or "bundling," of reimbursement for a Medicare beneficiary's episode of care at some point in the future; (3) implementing a voluntary program for accountable care organizations ("ACOs"); and (4) creating an Independent Payment Advisory Board.

Most notably for us, these laws include reductions in the annual market basket updates for hospitals and, as discussed below in "—Risks Related to the Acquisition of Encompass," home health and hospice providers. In accordance with Medicare laws and statutes, the United States Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS") makes annual adjustments to Medicare reimbursement rates by what is commonly known as a "market basket update." The reductions in the annual market basket updates for our hospitals continue through 2019 for each CMS fiscal year, which for us begins October 1, as follows:

2015-16	2017-19
0.2%	0.75%

In addition, the 2010 Healthcare Reform Laws require the market basket update to be reduced by a productivity adjustment on an annual basis. The productivity adjustments equal the trailing 10-year average of changes in annual economy-wide private nonfarm business multi-factor productivity. The productivity adjustment in effect for both fiscal year (October 1 to September 30) 2014 and 2015 is a decrease to the market basket update of 50 basis points.

The 2010 Healthcare Reform Laws also directed HHS to examine the feasibility of bundling, including conducting a voluntary, multi-year bundling pilot program to test and evaluate alternative payment methodologies. On January 31, 2013, CMS announced the selection of participants in the initial phase of limited-scope, voluntary bundling pilot projects. There are four project types: acute care only, acute/post-acute, post-acute only, and acute and physician services. In the initial non-risk bearing stage of the bundling program (Phase 1), pilot participants receive data from CMS on care patterns and engage in shared learning in how to improve care. The second phase (Phase 2) requires participants in that phase, pending contract finalization and completion of the standard CMS program integrity reviews, to take on financial risk for episodes of care. Whether any participant transitions from Phase 1 to Phase 2 is discretionary. In the current transition period, Phase 1 participants electing to move to Phase 2 will do so by either April or July 2015. CMS previously selected as participants a small number of acute care hospitals with which we have relationships. To date, we have agreed to participate in a few Model 2 (acute/post-acute) bundling projects as a post-acute rehabilitation provider, a couple of which have transitioned to Phase 2 for our acute care partners. We have also applied to enroll into Phase 2 a small number of our hospitals participating in Model 3 (post-acute only). We will continue to evaluate, on a case-by-case basis, the appropriateness of bundling opportunities for our operations and patients.

Similarly, in October 2011, CMS established, per the 2010 Healthcare Reform Laws, the Medicare Shared Savings Program ("MSSP"), a voluntary ACO program in which hospitals, physicians, and other care providers pursue the delivery of coordinated healthcare on a more efficient, patient-centered basis. Conceptually, ACOs will receive a portion of any savings generated above a certain threshold from care coordination as long as benchmarks for the quality of care are maintained. Under the MSSP, there are two different ACO tracks from which participants can choose. The first track allows ACOs to share only in the savings. The second track requires ACOs to share in any savings and losses but offers ACOs a greater share of any savings realized than the first track offers. In October 2014, CMS introduced a new initiative for ACOs participating in the MSSP. This new ACO investment model is designed to promote coordinated care in rural and under-served markets by offering pre-payment of shared savings in both up front and ongoing per beneficiary per month payments. The ACO rules adopted by CMS are extremely complex and remain subject to further refinement by CMS. As with bundling, we are currently evaluating, on a case-by-case basis, appropriate ACO participation opportunities for our hospitals and patients. We have expressed interest in participating in several ACOs and have executed one participation agreement as of December 31, 2014. Encompass is currently party to one newly formed ACO and is exploring several other participation opportunities.

The bundling and ACO initiatives have served as motivating factors for regulators and healthcare industry participants to identify and implement workable coordinated care delivery models. Broad-based implementation of a new delivery model would represent a significant transformation for us and the healthcare industry generally. The nature and timing of the transformation of the current healthcare system to coordinated care delivery and payment models is uncertain and will likely remain so for some time. The development of new delivery and payment systems will almost certainly take significant time and expense. Many of the alternative approaches being explored may not work or could change substantially prior to a nationwide implementation. For further discussion of the associated challenges and our efforts to respond to them, see the "Executive Overview—Key Challenges—Changes to Our Operating Environment Resulting from Healthcare Reform" section of Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

Another provision of the 2010 Healthcare Reform Laws establishes an Independent Payment Advisory Board appointed by the President that is charged with presenting proposals, beginning in 2014, to Congress to reduce Medicare expenditures upon the occurrence of Medicare expenditures exceeding a certain level. This board will have broad authority to develop new Medicare policies (including changes to provider reimbursement). In general, unless Congress acts to block the proposals of this board, CMS will implement the policy recommendations. However, due to the market basket reductions that are also part of these laws, certain healthcare providers, such as our inpatient rehabilitation hospitals, will not be subject to payment reduction proposals developed by this board and presented to Congress until 2020. While most of our operations may not be subject to its payment reduction proposals for a period of time, based on the scope of this board's directive to reduce Medicare expenditures and the significance of Medicare as a payor to us, other decisions made by this board may adversely impact our results of operations, including reductions in the payment for home health services. As of December 31, 2014, the Independent Payment Advisory Board members have not been appointed.

Many aspects of implementation and interpretation of the 2010 Healthcare Reform Laws remain uncertain. Given the complexity and the number of changes in these laws as well as subsequent regulatory developments and delays, we cannot predict the ultimate impact of these laws. However, we believe the provisions discussed above are the issues with the greatest potential impact on us.

The 2010 Healthcare Reform Laws include other provisions that could adversely affect us as well. They include the expansion of the federal Anti-Kickback Law and the False Claims Act that, when combined with other recent federal initiatives, are likely to increase investigation and enforcement efforts in the healthcare industry generally. Changes include increased resources for enforcement, lowered burden of proof for the government in healthcare fraud matters, expanded definition of claims under the False Claims Act, enhanced penalties, and increased rewards for relators in successful prosecutions. CMS may also suspend payment for claims prospectively if, in its opinion, credible allegations of fraud exist. The initial suspension period may be up to 180 days. However, the payment suspension period can be extended almost indefinitely if the matter is under investigation by the HHS Office of Inspector General (the "HHS-OIG") or the United States Department of Justice (the "DOJ"). Any such suspension would adversely impact our financial position, results of operations, and cash flows.

Further, under the 2010 Healthcare Reform Laws, CMS established new quality data reporting, effective October 1, 2012, for all inpatient rehabilitation facilities ("IRFs"). A facility's failure to submit the required quality data will result in a two percentage point reduction to that facility's annual market basket increase factor for payments made for discharges in a subsequent fiscal year. IRFs began submitting quality data to CMS in October 2012. All of our hospitals met the reporting deadlines occurring on or before December 31, 2013 resulting in no corresponding reimbursement reductions for fiscal year 2015. There can be no assurance all of our hospitals will do so for future periods which may result in one or more of our hospitals seeing a reduction in its reimbursements. Additionally, CMS requires reporting of two new quality measures, beginning January 1, 2015, and will conduct validation audits to ensure the completeness and accuracy of the quality data

submitted. Similarly, home health and hospice agencies are also required to submit quality data to CMS each year, and the failure to do so in accordance with the rules will result in a two percentage point reduction in their market basket update. For additional discussion of general healthcare regulation, see Item 1, *Business*, "Regulatory and Reimbursement Challenges" and "Regulation."

Some states in which we operate have also undertaken, or are considering, healthcare reform initiatives that address similar issues. While many of the stated goals of other federal and state reform initiatives are consistent with our own goal to provide care that is high-quality and cost-effective, legislation and regulatory proposals may lower reimbursements, increase the cost of compliance, decrease patient volumes, and otherwise adversely affect our business. We cannot predict what healthcare initiatives, if any, will be enacted, implemented or amended, or the effect any future legislation or regulation will have on us.

On August 2, 2011, President Obama signed into law the Budget Control Act of 2011, which provided for an automatic 2% reduction of Medicare program payments. This automatic reduction, known as "sequestration," which began affecting payments received after April 1, 2013, reduced the payments we receive under the IRF prospective payment system (the "IRF-PPS") resulting in a net year-over-year decrease in our *Net operating revenues* of approximately $9 million in 2014. The effect of sequestration on year-over-year comparisons of *Net operating revenues* ceased on April 1, 2014. However, each year through 2024, the reimbursement we receive from Medicare, after first taking into account all annual payment adjustments including the market basket update, will be reduced by sequestration unless it is repealed before then.

Additionally, concerns held by federal policymakers about the federal deficit, national debt levels, and reforming the sustainable growth rate formula used to pay physicians who treat Medicare beneficiaries (the so called "Doc Fix") could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, and/or further reductions to provider payments. For example, in October 2014, the President signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014 (the "IMPACT Act"). The IMPACT Act was developed on a bi-partisan basis by the House Ways and Means and Senate Finance Committees and incorporated feedback from healthcare providers and provider organizations that responded to the Committees' solicitation of post-acute payment reform ideas and proposals. It directs HHS, in consultation with healthcare stakeholders, to implement standardized data collection processes for post-acute quality and outcome measures. Although the IMPACT Act does not specifically call for the development of a new post-acute payment system, we believe this act will lay the foundation for possible future post-acute payment policies that would be based on patients' medical conditions and other clinical factors rather than the setting where the care is provided. It will create additional data reporting requirements for our hospitals and home health and hospice agencies. The precise details of these new reporting requirements, including timing and content, will be developed and implemented by CMS through the regulatory process that we expect will take place over the next several years. While we cannot quantify the potential financial effects of the IMPACT Act on HealthSouth, we believe any post-acute payment system that is data-driven and focuses on the needs and underlying medical conditions of post-acute patients ultimately will be a net positive for providers who offer high-quality, cost-effective care. However, it will likely take years for the related quality measures to be established, quality data to be gathered, standardized patient assessment data to be assembled and disseminated, and potential payment policies to be developed, tested, and promulgated.

Each year, the Medicare Payment Advisory Commission ("MedPAC"), an independent agency that advises Congress on issues affecting Medicare, makes payment policy recommendations to Congress for a variety of Medicare payment systems including the IRF-PPS, the home health prospective payment system, and the hospice prospective payment system. Congress is not obligated to adopt MedPAC's recommendations, and, based on outcomes in previous years, there can be no assurance Congress will adopt MedPAC's recommendations in a given year. For example, in recent years, Congress has not adopted any of the recommendations on the annual market basket update to Medicare payment rates under the IRF-PPS. We cannot predict what alternative or additional deficit reduction initiatives, Medicare payment reductions, or post-acute care reforms, if any, will ultimately be enacted into law, or the timing or effect any such initiatives or reductions will have on us. If enacted, such initiatives or reductions would likely be challenging for all providers, would likely have the effect of limiting Medicare beneficiaries' access to healthcare services, and could have an adverse impact on our financial position, results of operations, and cash flows.

If we are not able to maintain increased case volumes or reduce operating costs to offset any future pricing roll-back, reduction, freeze, or increased costs associated with new regulatory compliance obligations, our operating results could be adversely affected. Our results could be further adversely affected by other changes in laws or regulations governing the Medicare program, as well as possible changes to or expansion of the audit processes conducted by Medicare contractors or Medicare recovery audit contractors. For additional discussion of healthcare reform and other factors affecting reimbursement for our services, see Item 1, *Business*, "Regulatory and Reimbursement Challenges" and "Sources of Revenues—Medicare Reimbursement."

In addition, there are increasing pressures, including as a result of the 2010 Healthcare Reform Laws, from many third-party payors to control healthcare costs and to reduce or limit increases in reimbursement rates for medical services. Our relationships with managed care and nongovernmental third-party payors, such as health maintenance organizations and preferred provider organizations, are generally governed by negotiated agreements. These agreements set forth the amounts we are entitled to receive for our services. We could be adversely affected in some of the markets where we operate if we are unable to negotiate and maintain favorable agreements with third-party payors.

Our third-party payors may also, from time to time, request audits of the amounts paid, or to be paid, to us. We could be adversely affected in some of the markets where we operate if the auditing payor alleges substantial overpayments were made to us due to coding errors or lack of documentation to support medical necessity determinations.

Compliance with the extensive laws and government regulations applicable to healthcare providers requires substantial time, effort and expense, and if we fail to comply with them, we could suffer penalties or be required to make significant changes to our operations.

Healthcare providers are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These laws and regulations relate to, among other things:

- licensure, certification, and accreditation;
- policies, either at the national or local level, delineating what conditions must be met to qualify for reimbursement under Medicare (also referred to as coverage requirements);
- coding and billing for services;
- requirements of the 60% compliance threshold under the 2007 Medicare Act;
- relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws;
- quality of medical care;
- use and maintenance of medical supplies and equipment;
- maintenance and security of patient information and medical records;
- acquisition and dispensing of pharmaceuticals and controlled substances; and
- disposal of medical and hazardous waste.

In the future, changes in these laws or regulations or the manner in which they are enforced could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our hospitals, equipment, personnel, services, capital expenditure programs, operating procedures, and contractual arrangements, as well as the way in which we deliver home health and hospice services. Those changes could also affect reimbursements as well as future training and staffing costs. Of note, the HHS-OIG each year releases a work plan that identifies areas of compliance focus for the coming year.

Examples of regulatory changes that can affect our business, beyond direct changes to Medicare reimbursement rates, can be found from time to time in CMS rules. The final rule for the fiscal year 2010 IRF-PPS implemented new coverage requirements which provided in part that a patient medical record must document a reasonable expectation that, at the time of admission to an IRF, the patient generally required and was able to participate in the intensive rehabilitation therapy services uniquely provided at IRFs. CMS has also taken the position that a patient's medical file must appropriately document the rationale for the use of group therapies, as opposed to one-on-one therapy. As previously noted, the appropriate utilization of group therapy was a focus of recent HHS-OIG work plans. Beginning on October 1, 2015, a new data collection requirement will go into effect that will capture the minutes and mode (individual, group, concurrent, or co-treatment) of therapy by specialty. CMS plans to use this data to potentially support future rulemaking in this area. Additionally, the final rules for the fiscal years 2014 and 2015 IRF-PPS include changes, effective October 1, 2015, to the list of medical conditions, including a reduction in the number of conditions, that will presumptively count toward the 60% compliance threshold to qualify for reimbursement as an inpatient rehabilitation hospital.

The clarity and completeness of each patient medical file, some of which is the work product of a physician not employed by us, are essential to demonstrating our compliance with various regulatory and reimbursement requirements. For

example, to support the determination that a patient's IRF treatment was reasonable and necessary, the file must contain, among other things, an admitting physician's assessment of the patient as well as a post-admission assessment by the treating physician and other information from clinicians relating to the plan of care and the therapies being provided. These physicians exercise their independent medical judgment. We and our hospital medical directors, who are independent contractors, provide training to the physicians we work with on a regular basis regarding appropriate documentation. In connection with subsequent payment audits and investigations, there can be no assurance as to what opinion a third party may take regarding the status of patient files or the physicians' medical judgment evidenced in those files.

The 2012 and 2013 HHS-OIG work plans for IRFs focused on timely submissions of patient assessment instruments, the examination of the level of therapy being provided, and the appropriate utilization of concurrent and group therapy. The 2014 work plan provides that the HHS-OIG will review matters related to adverse and temporary harm events occurring in IRFs, and conduct audits of home health claims to ensure documentation exists to support payments. In addition, the 2015 work plan indicates HHS-OIG will review the home health prospective payment system requirements.

On March 4, 2013, we received document subpoenas from an office of the HHS-OIG addressed to four of our hospitals. Those subpoenas requested complete copies of medical records for 100 patients treated at each of those hospitals between September 2008 and June 2012. The investigation is being conducted by the DOJ. On April 24, 2014, we received document subpoenas relating to an additional seven of our hospitals. The new subpoenas reference substantially similar investigation subject matter as the original subpoenas and request materials from the period January 2008 through December 2013. Two of the four hospitals addressed in the original set of subpoenas have received supplemental subpoenas to cover this new time period. The new subpoenas do not include requests for specific patient files, but it is expected that such requests will be made for the new group of hospitals.

All of the subpoenas are in connection with an investigation of alleged improper or fraudulent claims submitted to Medicare and Medicaid and requests documents and materials relating to practices, procedures, protocols and policies, of certain pre- and post-admissions activities at these hospitals including, among other things, marketing functions, pre-admission screening, post-admission physician evaluations, patient assessment instruments, individualized patient plans of care, and compliance with the Medicare 60% rule. Under the Medicare rule commonly referred to as the "60% rule," an inpatient rehabilitation hospital must treat 60% or more of its patients from at least one of a specified list of medical conditions in order to be reimbursed at the inpatient rehabilitation hospital payment rates, rather than at the lower acute care hospital payment rates. We are currently unable to predict the timing or outcome of these investigations, and the DOJ has expressly reserved its right to make additional requests.

Although we have invested, and will continue to invest, substantial time, effort, and expense in implementing and maintaining training programs as well as internal controls and procedures designed to ensure regulatory compliance, if we fail to comply with applicable laws and regulations, we could be required to return portions of reimbursements for discharges deemed after the fact to have not been appropriate under the IRF-PPS. We could also be subjected to other liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs, which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement. Because Medicare comprises a significant portion of our *Net operating revenues*, it is important for us to remain compliant with the laws and regulations governing the Medicare program and related matters including anti-kickback and anti-fraud requirements. As discussed above in connection with the 2010 Healthcare Reform Laws, the federal government has in the last couple of years made compliance enforcement and fighting healthcare fraud top priorities. In the past few years, the DOJ and HHS as well as federal lawmakers have significantly increased efforts to ensure strict compliance with various reimbursement related regulations as well as combat healthcare fraud. The DOJ has pursued and recovered a record amount of taxpayer dollars lost to healthcare fraud. Additionally, the federal government has become increasingly aggressive in asserting that incidents of erroneous billing or record keeping represent a violation of the False Claims Act.

Reductions in reimbursements, substantial damages and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation.

Reimbursement claims are subject to various audits from time to time and such audits may delay or reduce receipt of the related reimbursement amounts for services previously provided.

Reimbursement claims made by health care providers, including inpatient rehabilitation hospitals as well as home health and hospice agencies, are subject to audit from time to time by governmental payors and their agents, such as the Medicare Administrative Contractors ("MACs"), fiscal intermediaries and carriers, as well as the OIG, CMS and state Medicaid programs. Depending on the nature of the conduct found in such audits and whether the underlying conduct could be

considered systemic, the resolution of these audits could have an adverse effect on our financial position, results of operation and liquidity.

With respect to the Medicare program, from which we receive a substantial portion of our revenues, CMS has developed and instituted various audit programs under which CMS contracts with private companies to conduct claims and medical record audits. These audits are in addition to those conducted by existing MACs. Some contractors are paid a percentage of the overpayments recovered. One type of audit contractor, the Recovery Audit Contractors ("RACs"), receive claims data directly from MACs on a monthly or quarterly basis and are authorized to review claims up to three years from the date a claim was paid, beginning with claims filed on or after October 1, 2007.

RAC audits of IRFs initially focused on coding errors, but have subsequently been expanded to medical necessity reviews. In connection with CMS approved and announced RAC audits related to IRFs, we received requests to review certain patient files for discharges occurring from 2010 to 2014. To date, the Medicare payments that are subject to these audit requests represent less than 1% of our Medicare patient discharges during those years, and not all of these patient files requests have resulted in payment denial determinations by the RACs. These post-payment RAC audits are focused on medical necessity requirements for admission to IRFs rather than targeting a specific diagnosis code as in previous pre-payment audits. Medical necessity is a subjective assessment by an independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting. Because we have confidence in the medical judgment of both the referring and the admitting physicians who assess the treatment needs of our patients, we have appealed substantially all RAC denials arising from these audits.

The contracts awarded to RACs by CMS were set to expire in February 2014, but they have been extended and modified pending finalization of new contracts. In late February 2014, CMS announced it would pause the operations of the current RACs until new contracts are awarded, meaning that hospitals would not receive any new requests from RACs until that time. Legal challenges to the contract award process have delayed finalizing the new contracts longer than expected, and as a result, CMS modified the existing RAC contracts to allow some RAC reviews to be restarted on a limited basis. Additionally, on December 30, 2014, CMS announced the beginning of a new contract for the RAC assigned to audit payments for home health and hospice services, which has subsequently been delayed by another challenge. Once the new contracts are in place, whether for IRFs or home health and hospice agencies, the associated RACs will be able to audit claims for dates of service during the time period covered by the pause in RAC operations.

We cannot predict when the legal challenges to the new contracts will be resolved or when CMS will otherwise finalize the new RAC contracts. While we make provisions for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs, we cannot provide assurance as to our future success in the resolution of these and future disputes, nor can we predict or estimate the scope or number of denials that ultimately may be received. However, due to additional delays announced by CMS in the related adjudication process, we believe the resolution of any claims that are subsequently denied as a result of these RAC audits could take in excess of two years.

On August 27, 2012, CMS launched its three-year demonstration project that expanded the RAC program to include prepayment review of Medicare fee-for-service claims. Currently, acute care hospitals are the primary subject of this review project, but CMS could expand it to inpatient post-acute providers. This demonstration project will identify specific diagnosis codes for review, and the RAC contractors will review the selected claims to determine if they are proper before payment has been made to the provider. The project covers 11 states, including some states in which we operate, such as Florida, California, Texas, and Pennsylvania. Providers with claims identified for RAC prepayment reviews will have 30 days to respond to requests for additional documentation. If they do not respond timely, the claim will be denied. Providers receive determinations within 45 days of submitting the relevant documentation.

CMS has also established contractors known as the Zone Program Integrity Contractors ("ZPICs"). These contractors are successors to the Program Safeguard Contractors and conduct audits with a focus on potential fraud and abuse issues. Like the RACs, the ZPICs conduct audits and have the ability to refer matters to the HHS-OIG or the DOJ. Unlike RACs, however, ZPICs do not receive a specific financial incentive based on the amount of the error.

Audits may lead to assertions that we have been underpaid or overpaid by Medicare or submitted improper claims in some instances, require us to incur additional costs to respond to requests for records and defend the validity of payments and claims, and ultimately require us to refund any amounts determined to have been overpaid or disallow reimbursement. As a result, we may suffer reduced profitability. Our right to appeal audit determinations may lead to cash flow delays. We cannot predict when or how these audit programs will affect us.

We face national, regional, and local competition for patients from other healthcare providers.

We operate in a highly competitive industry. Although we are the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues, and number of hospitals, in any particular market we may encounter competition from local or national entities with longer operating histories or other competitive advantages. For example, acute care hospitals, including those owned and operated by large public companies, may choose to expand or begin offering post-acute rehabilitation services. Given that approximately 92% of our hospitals' referrals come from acute care hospitals, that increase in competition might materially and adversely affect our admission referrals in the related markets. For a discussion of the competition risks faced by our home health and hospice business, see "—Competition among home health and hospice service companies is intense" below. There can be no assurance this competition, or other competition which we may encounter in the future, will not adversely affect our business, financial position, results of operations, or cash flows. In addition, from time to time, there are efforts in states with certificate of need ("CON") laws to weaken those laws, which could potentially increase competition in those states. Conversely, competition and statutory procedural requirements in some CON states may inhibit our ability to expand our operations. For a breakdown of the CON status of the states and territories in which we have operations, see Item 2, *Properties*.

We may have difficulty completing investments and transactions that increase our capacity consistent with our growth strategy.

We are selectively pursuing strategic acquisitions of, and in some instances joint ventures with, other healthcare providers. We may face limitations on our ability to identify sufficient acquisition or other development targets and to complete those transactions to meet goals. In many states, the need to obtain governmental approvals, such as a CON or an approval of a change in ownership, may operate as a significant obstacle to completing transactions. Additionally, in states with CON laws, it is not unusual for third-party providers to challenge initial awards of CONs, the increase in the number of approved beds in an existing CON, or expand or change the area served, and the adjudication of those challenges and related appeals may take multiple years.

We may make investments or complete transactions that may be unsuccessful and could expose us to unforeseen liabilities.

Investments, acquisitions, joint ventures or other development opportunities identified and completed may involve material cash expenditures, debt incurrence, operating losses, amortization of certain intangible assets of acquired companies, issuances of equity securities, and expenses, some of which are unforeseen, that could affect our business, financial position, results of operations and liquidity. Acquisitions, investments, and joint ventures involve numerous risks, including:

- limitations, including state CONs as well as CMS and other regulatory approval requirements, on our ability to complete such acquisitions, particularly those involving not-for-profit providers, on terms, timetables, and valuations reasonable to us;
- limitations in obtaining financing for acquisitions at a cost reasonable to us;
- difficulties integrating acquired operations, personnel, and information systems, and in realizing projected revenues, efficiencies and cost savings, or returns on invested capital;
- entry into markets, businesses or services in which we may have little or no experience;
- diversion of business resources or management's attention from ongoing business operations; and
- exposure to undisclosed or unforeseen liabilities of acquired operations, including liabilities for failure to comply with healthcare laws and anti-trust considerations in specific markets.

In addition to those development activities, we intend to build new, or de novo, inpatient rehabilitation hospitals. The construction of new hospitals involves numerous risks, including the receipt of all zoning and other regulatory approvals, such as a CON where necessary, construction delays and cost over-runs. Once built, new hospitals must undergo the state and Medicare certification process, the duration of which may be beyond our control. We may be unable to operate newly constructed hospitals as profitably as expected, and those hospitals may involve significant additional cash expenditures and operating expenses that could, in the aggregate, have an adverse effect on our business, financial position, results of operations, and cash flows.

Competition for staffing, shortages of qualified personnel, union activity or other factors may increase our labor costs and reduce profitability.

Our operations are dependent on the efforts, abilities, and experience of our medical personnel, such as physical therapists, occupational therapists, speech pathologists, nurses, and other healthcare professionals. We compete with other healthcare providers in recruiting and retaining qualified personnel responsible for the daily operations of each of our locations. In some markets, the lack of availability of medical personnel is a significant operating issue facing all healthcare providers. This shortage may require us to continue to enhance wages and benefits to recruit and retain qualified personnel or to contract for more expensive temporary personnel. We also depend on the available labor pool of semi-skilled and unskilled employees in each of the markets in which we operate.

If our labor costs increase, we may not experience reimbursement rate increases to offset these additional costs. Because a significant percentage of our revenues consists of fixed, prospective payments, our ability to pass along increased labor costs is limited. In particular, if labor costs rise at an annual rate greater than our net annual market basket update from Medicare, our results of operations and cash flows will be adversely affected. Conversely, decreases in reimbursement revenues, such as with sequestration, may limit our ability to increase compensation or benefits to the extent necessary to retain key employees, in turn increasing our turnover and associated costs. Union activity is another factor that may contribute to increased labor costs. Our failure to recruit and retain qualified medical personnel, or to control our labor costs, could have a material adverse effect on our business, financial position, results of operations, and cash flows.

We are a defendant in various lawsuits, and may be subject to liability under qui tam cases, the outcome of which could have a material adverse effect on us.

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. We are a defendant in a number of lawsuits. The material lawsuits and investigations, including the subpoenas received from HHS-OIG, are discussed in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements. Substantial damages, fines, or other remedies assessed against us or agreed to in settlements could have a material adverse effect on our business, financial position, results of operations, and cash flows. Additionally, the costs of defending litigation and investigations, even if frivolous or nonmeritorious, could be significant.

We insure a substantial portion of our professional liability, general liability, and workers' compensation liability risks through our captive insurance subsidiary, as discussed further in Note 9, *Self-Insured Risks*, to the accompanying consolidated financial statements. Changes in the number of these liability claims and the cost to resolve them impact the reserves for these risks. A variance between our estimated and actual number of claims or average cost per claim could have a material impact, either favorable or unfavorable, on the adequacy of the reserves for these liability risks, which could have an effect on our financial position and results of operations.

The False Claims Act allows private citizens, called "relators," to institute civil proceedings alleging violations of the False Claims Act. These *qui tam* cases are sealed by the court at the time of filing. Prior to the lifting of the seal by the court, the only parties typically privy to the information contained in the complaint are the relator, the federal government, and the presiding court. It is possible that *qui tam* lawsuits have been filed against us and that those suits remain under seal or that we are unaware of such filings or prevented by existing law or court order from discussing or disclosing the filing of such suits. We may be subject to liability under one or more undisclosed *qui tam* cases brought pursuant to the False Claims Act.

The proper function, availability, and security of our information systems are critical to our business.

We are and will remain dependent on the proper function, availability and security of our and third-party information systems, including our electronic clinical information system (the "CIS") which plays a substantial role in the operations of the hospitals in which it is installed and any information systems currently in use by Encompass. We undertake substantial measures to protect the safety and security of our information systems and the data maintained within those systems, and we regularly test the adequacy of our security and disaster recovery measures. We have implemented administrative, technical and physical controls on our systems and devices in an attempt to prevent unauthorized access to that data, which includes protected health information subject to the protections of the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act and other sensitive information. For additional discussion of these laws, see Item 1, *Business*, "Regulation." As part of our efforts, we may be required to expend significant capital to protect against the threat of security breaches, including cyber-attacks, or to alleviate problems caused by breaches, including unauthorized access to patient data and protected health information stored in our information systems and the introduction of computer malware to our systems. However, given the rapidly evolving nature of cyber threats, there can be no assurance our safety and security measures or network security or other controls will detect and prevent security or data breaches, including

cyber-attacks, in a timely manner or otherwise prevent unauthorized access to, damage to, or interruption of our systems and operations. We may be vulnerable to losses associated with the improper functioning, security breach or unavailability of our information systems as well as any systems used in acquired operations such as Encompass. A compromise of our safety and security measures, or network security or other controls, or of those businesses with whom we interact, which results in confidential information being accessed, obtained, damaged or used by unauthorized or improper persons, could harm our reputation and expose us to significant remedial costs as well as regulatory actions and claims from patients, financial institutions, and other persons, any of which could adversely affect our business, financial position, results of operations and cash flows. Moreover, a security breach could require that we expend significant resources related to our information systems and infrastructure, and could distract management and other key personnel from performing their primary operational duties. In the case of a material breach or cyber-attack, the associated expenses and losses may exceed our current insurance coverage for such events. Failure to maintain proper function, security, or availability of our information systems or protect our data against unauthorized access could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Our CIS is subject to a licensing, implementation, technology hosting, and support agreement with Cerner Corporation. In June 2011, we entered into an agreement with Cerner to begin a company-wide implementation of this system in 2012. As of December 31, 2014, we have installed the CIS in 58 hospitals with another 24 installations scheduled for 2015. We expect to complete installation in our existing hospitals by the end of 2017. Our inability, or the inability of Cerner, to continue to maintain and upgrade our information systems, software, and hardware could disrupt or reduce the efficiency of our operations. In addition, costs, unexpected problems, and interruptions associated with the implementation or transition to new systems or technology or with adequate support of those systems or technology across multiple hospitals could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Successful execution of our current business plan depends on our key personnel.

The success of our current business plan depends in large part upon the leadership and performance of our executive management team and key employees and our ability to retain and motivate these individuals. We rely upon their ability, expertise, judgment, discretion, integrity and good faith. There can be no assurance that we will retain our key executives and employees or that we can attract or retain other highly qualified individuals in the future. If we lose key personnel, we may be unable to replace them with personnel of comparable experience in, or knowledge of, the healthcare provider industry or our specific post-acute segment. The loss of the services of any of these individuals could prevent us from successfully executing our business plan and could have a material adverse effect on our business and results of operations.

Our leverage or level of indebtedness may have negative consequences for our business, and we may incur additional indebtedness in the future.

Although we have reduced our outstanding long-term debt substantially in recent years, we still had approximately $2.0 billion of long-term debt outstanding (including that portion of long-term debt classified as current and excluding $86.7 million in capital leases) as of December 31, 2014. See Note 8, *Long-term Debt*, to the accompanying consolidated financial statements. Subject to specified limitations, our credit agreement and the indentures governing our debt securities permit us and our subsidiaries to incur material additional debt. If new debt is added to our current debt levels, the risks described here could intensify.

Our indebtedness could have important consequences, including:

- limiting our ability to borrow additional amounts to fund working capital, capital expenditures, acquisitions, debt service requirements, execution of our business strategy and other general corporate purposes;
- making us more vulnerable to adverse changes in general economic, industry and competitive conditions, in government regulation and in our business by limiting our flexibility in planning for, and making it more difficult for us to react quickly to, changing conditions;
- placing us at a competitive disadvantage compared with competing providers that have less debt; and
- exposing us to risks inherent in interest rate fluctuations for outstanding amounts under our credit facility, which could result in higher interest expense in the event of increases in interest rates.

We are subject to contingent liabilities, prevailing economic conditions, and financial, business, and other factors beyond our control. Although we expect to make scheduled interest payments and principal reductions, we cannot provide assurance that changes in our business or other factors will not occur that may have the effect of preventing us from satisfying

obligations under our debt instruments. If we are unable to generate sufficient cash flow from operations in the future to service our debt and meet our other needs, we may have to refinance all or a portion of our debt, obtain additional financing or reduce expenditures or sell assets we deem necessary to our business. We cannot provide assurance these measures would be possible or any additional financing could be obtained.

The restrictive covenants in our credit agreement and the indentures governing our senior notes could affect our ability to execute aspects of our business plan successfully.

The terms of our credit agreement and the indentures governing our senior notes do, and our future debt instruments may, contain various provisions that limit our ability and the ability of certain of our subsidiaries to, among other things:

- incur or guarantee indebtedness;
- pay dividends on, or redeem or repurchase, our capital stock; or repay, redeem or repurchase our subordinated obligations;
- issue or sell certain types of preferred stock;
- make investments;
- incur obligations that restrict the ability of our subsidiaries to make dividends or other payments to us;
- sell assets;
- engage in transactions with affiliates;
- create certain liens;
- enter into sale/leaseback transactions; and
- merge, consolidate, or transfer all or substantially all of our assets.

These covenants could adversely affect our ability to finance our future operations or capital needs and pursue available business opportunities. For additional discussion of our material debt covenants, see the "Liquidity and Capital Resources" section of Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, and Note 8, *Long-term Debt*, to the accompanying consolidated financial statements.

In addition, our credit agreement requires us to maintain specified financial ratios and satisfy certain financial condition tests. See the "Liquidity and Capital Resources" section of Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, and Note 8, *Long-term Debt*, to the accompanying consolidated financial statements. Although we remained in compliance with the financial ratios and financial condition tests as of December 31, 2014, we cannot provide assurance we will continue to do so. Events beyond our control, including changes in general economic and business conditions, may affect our ability to meet those financial ratios and financial condition tests. A severe downturn in earnings or, if we have outstanding borrowings under our credit facility at the time, a rapid increase in interest rates could impair our ability to comply with those financial ratios and financial condition tests and we may need to obtain waivers from the required proportion of the lenders to avoid being in default. If we try to obtain a waiver or other relief from the required lenders, we may not be able to obtain it or such relief might have a material cost to us or be on terms less favorable than those in our existing debt. If a default occurs, the lenders could exercise their rights, including declaring all the funds borrowed (together with accrued and unpaid interest) to be immediately due and payable, terminating their commitments or instituting foreclosure proceedings against our assets, which, in turn, could cause the default and acceleration of the maturity of our other indebtedness. A breach of any other restrictive covenants contained in our credit agreement or the indentures governing our senior notes would also (after giving effect to applicable grace periods, if any) result in an event of default with the same outcome.

As of December 31, 2014, approximately 75% of our consolidated *Property and equipment, net* was held by HealthSouth Corporation and its guarantor subsidiaries under our credit agreement. See Note 8, *Long-term Debt*, and Note 20, *Condensed Consolidating Financial Information*, to the accompanying consolidated financial statements, and Item 2, *Properties*.

Uncertainty in the capital markets could adversely affect our ability to carry out our development objectives.

The global and sovereign credit markets have experienced significant disruptions in recent years, and in 2013, the debt ceiling and federal budget disputes in the United States affected capital markets. Future market shocks could negatively affect the availability or terms of certain types of debt and equity financing, including access to revolving lines of credit. Future business needs combined with market conditions at the time may cause us to seek alternative sources of potentially less attractive financing and may require us to adjust our business plan accordingly. For example, tight credit markets, such as might result from further turmoil in the sovereign debt markets, would likely make additional financing more expensive and difficult to obtain. The inability to obtain additional financing at attractive rates or prices could have a material adverse effect on our financial performance or our growth opportunities.

As a result of credit market uncertainty, we also face potential exposure to counterparties who may be unable to adequately service our needs, including the ability of the lenders under our credit agreement to provide liquidity when needed. We monitor the financial strength of our depositories, creditors, and insurance carriers using publicly available information, as well as qualitative inputs.

Risks Related to the Acquisition of Encompass (the "Acquisition")

The anticipated benefits of the Acquisition may not be realized, which could adversely impact our business and our operating results.

We anticipate the Acquisition will result in benefits including, among other things, enhanced revenues and our enhanced ability to provide a continuum of facility-based and home-based post-acute services. The acquired business may underperform relative to our expectations, including failing to continue to acquire and integrate other home health and hospice providers to the degree expected. If the acquired business underperforms and such underperformance is other than temporary, we may be required to take an impairment charge.

Achieving the anticipated benefits of the Acquisition is subject to a number of uncertainties, including general competitive factors in the marketplace. The acquired business may not contribute to our revenues or earnings to the extent anticipated, and the synergies we expect from the Acquisition may not be realized. Additionally, the costs or difficulties related to the integration of Encompass' business and operations into ours could be greater than expected, and the Acquisition could cause disruption to our business and operations and our relationships with customers, employees and other parties. Failure to achieve the anticipated benefits could result in increased costs, decreases in the amount of expected revenues, inability to meet the financial ratios and financial condition tests under our credit agreement and diversion of management's time and energy and could have an adverse effect on our business, financial position, results of operations, and cash flows. Thus, the anticipated benefits of the Acquisition may not be realized, and significant time and cost beyond that anticipated may be required in connection with the integration of HealthSouth and Encompass.

Encompass, with a substantial portion of its revenues derived from Medicare, is subject to many of the same risks as HealthSouth's inpatient rehabilitation business. The reader should review the risks under "Risks Related to Our Business," including "—Compliance with the extensive laws and government regulations applicable to healthcare providers requires substantial time, effort and expense, and if we fail to comply with them, we could suffer penalties or be required to make significant changes to our operations," "—We are a defendant in various lawsuits, and may be subject to liability under qui tam cases, the outcome of which could have a material adverse effect on us," and "—The proper function, availability, and security of our information systems are critical to our business."

We may not be able to successfully integrate Encompass.

Prior to consummation of the Acquisition, Encompass operated independently of us, with its own business, corporate culture, locations, employees and systems. We will in some respects operate our existing business, along with the business of Encompass, as one combined organization, for example utilizing certain common information systems, operating procedures, administrative functions, financial and internal controls and human resources practices. There may be substantial difficulties, costs and delays involved in the integration of Encompass with our business. In addition, Encompass itself has grown through acquisitions, and there may be legacy systems, operating policies and procedures, financial and administrative practices yet to be fully integrated within Encompass. The failure to successfully integrate Encompass with our business could have an adverse effect on our business, financial position, results of operations, and cash flows.

Reductions or changes to the reimbursement mechanisms from government payors and other legislative and regulatory changes affecting the home health and hospice businesses could adversely affect Encompass' operating results.

Encompass derives a substantial portion of its net operating revenues from the Medicare program. As noted above, from time to time legislative and regulatory changes have resulted in limitations on the increases and, in some cases, significant roll-backs or reductions, in the levels of payments to healthcare providers for services under many government reimbursement programs. There can be no assurance future governmental initiatives will not result in pricing roll-backs, freezes or other reimbursement reductions.

As discussed in "—Reductions or changes in reimbursement from government or third-party payors and other legislative and regulatory changes affecting our industry could adversely affect our operating results," the 2010 Healthcare Reform Laws have impacted and will in the future continue to impact home health and hospice care providers. For example, the 2010 Healthcare Reform Law directed CMS to improve home health payment accuracy through rebasing home health payments over four years starting in 2014. The rebasing adjustment for calendar year 2015 resulted in an approximately 2.4% reduction to the annual market basket update determined by CMS. In addition, the laws also require an annual home health productivity adjustment beginning on January 1, 2015. For calendar year 2015, that adjustment is a decrease to the market basket update of 50 basis points.

For hospice services, the 2010 Healthcare Reform laws require, in addition to the annual productivity adjustment, further reduction of the annual market basket update of 30 basis points for fiscal years 2013 through 2019. The hospice productivity adjustment for the fiscal year beginning October 1, 2014 was a decrease to the market basket update of 50 basis points.

CMS recently hired ABT & Associates to examine and recommend changes to the home health outlier payment calculation methodology. Changes to how the larger outlier payments are calculated could adversely affect Encompass' revenues with respect to these payments. In addition, in August 2014, MedPAC provided CMS with its comments on CMS's 2015 home health prospective payment system update, changes to the face-to-face visit requirement, recalibration of the payment weights for home health resource groups, changes to the pay-for reporting program and changes to the value-based purchasing model.

Specifically, MedPAC recommended (i) accelerating rebasing cuts and legislative changes to make the cuts larger in size considering the 3.5% reduction will not effectively remove margins, (ii) requiring home health recipients to make copayments for services, (iii) implementing readmission penalties on home health outcomes similar to penalties levied in acute care services, (iv) overhauling the home health prospective payment system to pay providers based on patient characteristics in lieu of the number of services furnished, (v) keeping the physician face-to-face narrative as a requirement in effect for at least another year while CMS considers potential modifications, (vi) CMS analyzing the change in the reported average case-mix to determine whether a payment adjustment is warranted, and (vii) implementing a value-based purchasing demonstration by fiscal year 2016.

There can be no assurance these recommendations and initiatives or other future governmental action will not result in substantial changes to home health and hospice operations or material reductions in reimbursements.

Competition among home health and hospice service companies is intense.

The home health and hospice services industry is highly competitive and fragmented. Our primary competition comes from locally owned private home health companies or acute-care hospitals with adjunct home health services and typically varies from market to market. We compete with a variety of other companies in providing home health and hospice services, some of which may have greater financial and other resources and may be more established in their respective communities. Competing companies may offer newer or different services from those we offer or have better relationships with referring physicians and may thereby attract patients who are presently, or would be candidates for, receiving Encompass home health or hospice services.

Some of Encompass' current and potential competitors, which include a number of other public companies, have or may obtain significantly greater marketing and financial resources than Encompass has or may obtain. Relatively few barriers to entry exist in most of Encompass' local markets. Accordingly, other companies, including hospitals and other healthcare organizations that are not currently providing competing services, may expand their services to include home health services, hospice care, community care services, or similar services. Encompass may encounter increased competition in the future that could negatively impact patient referrals to Encompass, limit its ability to maintain or increase its market position and adversely affect Encompass' profitability.

Beginning in January 2015, hospice agencies will be required by CMS to complete a Hospice Experience of Care Survey. As part of this new survey, the survey data will be made available to the public when 12 months of data are available. In addition to the likely additional costs associated with implementing and responding to the survey, competing companies may use the disclosed information in their marketing and other strategic materials which could negatively impact patient referrals to Encompass, limit its ability to maintain or increase its market position, and adversely affect Encompass' profitability.

If we are unable to maintain or develop relationships with patient referral sources, our growth and profitability could be adversely affected.

The success of home health and hospice providers depends substantially on referrals from physicians, hospitals, case managers and other patient referral sources in the communities served. Referral sources are not contractually obligated to refer home care patients to us and may refer their patients to other providers. Our growth and profitability depend on our ability to establish and maintain close working relationships with these patient referral sources and to increase awareness and acceptance of the benefits of home health and hospice care by our referral sources and their patients. We cannot provide assurance that we will be able to maintain our existing referral source relationships or that we will be able to develop and maintain new relationships in existing or new markets. Our loss of, or failure to maintain, existing relationships or our failure to develop new relationships could adversely affect our ability to grow our business and operate profitably.

Given our intention to expand our presence in home health and hospice, we are subject to risks in a market in which we have limited experience.

The majority of our experience has historically been as an owner and operator of inpatient rehabilitation hospitals. An important aspect of the Acquisition was retention of its management team. If we decide to further expand our presence in home health or hospice or other relevant healthcare services, our existing overall business model may change, and we may become subject to risks in a market in which we have limited experience. In most states, home health is regulated by different agencies than those that regulate inpatient rehabilitation hospitals, and we have less experience with the agencies that regulate home health. If we decide to expand our presence in home health and hospice, we might have to adjust part of our existing business model, which could have an adverse effect on our business, financial position, results of operations, and cash flows.

We rely extensively on the experience and expertise of Encompass' management team. In order to retain this experience and expertise, we have entered into three-year employment agreements that include noncompetition and other restrictive covenants with certain key senior management personnel of Encompass. However, there is no guarantee we will be able to retain these individuals or other members of Encompass' management team. If we are unable to retain these members of Encompass' senior management, we could face increased difficulties in operating Encompass and in expanding our presence in home health and hospice.

For additional discussion of risks related to our future growth, see "Risks Related to Our Business—We may have difficulty completing investments and transactions that increase our capacity consistent with our growth strategy," "—We may make investments or complete transactions that may be unsuccessful and could expose us to unforeseen liabilities," and "— Successful execution of our current business plan depends on our key personnel."

If any of Encompass' home health or hospice programs fail to comply with the Medicare conditions of participation, that program could be terminated from the Medicare program.

Each of Encompass' home health and hospice agencies must comply with extensive conditions of participation for certification in the Medicare program. If any of Encompass' home health or hospice programs fail to meet any of the Medicare conditions of participation, that program may receive a notice of deficiency from the applicable state survey agency. If that home health or hospice agency then fails to institute an acceptable plan of correction and correct the deficiency within the applicable correction period, that program could be terminated from receiving Medicare payments. For example, the conditions require that hospice programs have a certain number of volunteers. A program could be terminated from the Medicare benefit if the program fails to address the deficiency within the applicable correction period. If CMS terminates one program or agency, it may increase its scrutiny of other agencies under common control. Additionally, in October 2014, CMS proposed revisions to the Medicare conditions of participation applicable to home health agencies and intended to provide home health agencies with enhanced flexibility while focusing provider efforts on patient services, quality of care, and quality assessment and performance improvement efforts. More specifically, CMS proposed to establish four new conditions of participation (in addition to retaining current requirements related to comprehensive assessment of patients) for: (1) patient rights; (2) care planning, coordination of services, and quality of care, requiring an interdisciplinary team approach to provide home health services; (3) quality assessment and performance improvement, requiring each home health agency to conduct ongoing quality assessments, incorporate data-driven goals, and maintain an evidence-based performance improvement program of its own design to affect continuing improvement in the quality of patient care; and (4) infection prevention and control. We cannot

predict when or what, if any, changes will be made or the impact on us. We believe Encompass is in substantial compliance with the conditions of participation; however, we cannot predict how surveyors will interpret all aspects of the Medicare conditions of participation. Any termination of one or more of Encompass' home health or hospice programs from the Medicare program for failure to satisfy the conditions of participation could adversely affect its patient service revenue and profitability and financial condition.

We could experience significant malpractice or other similar claims.

Home care services, by their very nature, are provided in an environment, the patient's place of residence, that is not in the substantial control of the healthcare provider. Accordingly, home care involves an increased level of associated risk of general and professional liability. On any given day, Encompass has thousands of nurses, therapists and other care providers driving to and from the homes of patients where they deliver care. We cannot predict the impact that any claims arising out of the travel, the home visits or the care being provided, regardless of their ultimate outcome, could have on our business or reputation or on our ability to attract and retain patients and employees. We also cannot predict the adequacy of any reserves for such losses or recoveries from any insurance or re-insurance policies.

We could experience significant increases to our operating costs due to shortages of qualified home health and hospice employees and other healthcare professionals or union activity.

The market for qualified home health and hospice employees and other healthcare professionals is highly competitive. Encompass, like other healthcare providers, may experience difficulties in attracting and retaining qualified personnel such as nurses, certified nurse's assistants, nurse's aides, therapists, home health and hospice employees and other providers of healthcare services. Encompass' home health and hospice operations are particularly dependent on nurses and other employees for patient care. As the demand for home health services and hospice services continues to exceed the supply of available and qualified staff, home health operators and their competitors have been forced to offer more attractive wage and benefit packages to these professionals. Any difficulty Encompass may experience in hiring and retaining qualified personnel may increase its average wage rates and may force it to increase its use of contract personnel.

In addition, healthcare providers are experiencing a high level of union activity across the country. Encompass currently has no unionized employees. Although we cannot predict the degree to which Encompass will be affected by future union activity, there are continuing legislative proposals that could result in increased union activity. Encompass could experience an increase in labor and other costs from union activity. Furthermore, Encompass could experience a disruption of its operations if its employees were to engage in a strike or other work stoppage.

Encompass may experience increases in its labor costs primarily due to higher wages and greater benefits required to attract and retain qualified healthcare personnel. Our inability to adequately manage Encompass' labor costs may adversely affect our future operating results.

Encompass' hospice operations are subject to annual Medicare caps calculated by Medicare and potential changes in the Medicare reimbursement methodology.

With respect to Encompass' hospice operations, overall payments made by Medicare to each hospice provider number are subject to an inpatient cap amount and an overall payment cap, which are calculated and published by the Medicare fiscal intermediary on an annual basis covering the period from November 1 through October 31. If payments received under any one of Encompass' hospice provider numbers exceeds either of these caps, it may be required to reimburse Medicare for payments received in excess of the caps, which could have an adverse effect on our business, financial position, results of operations, and cash flows. CMS and MedPAC are currently working on amending the timing requirements of refunding overpayments related to hospice payments, which may have an adverse effect on Encompass' cash flows. In addition, MedPAC has recommended that CMS work to develop an alternative payment system for hospice services. Over the last several years, CMS examined an alternative payment system for hospices (including adding a case-mix adjustment to the system) and found that costs varied at different stages of a hospice stay-with higher costs accruing at the beginning and end of an episode. As a result, CMS is examining adjusting the payment system by implementing a short-stay policy. There can be no assurance the foregoing recommendations will not result in substantial changes to hospice reimbursements Encompass is entitled to receive from Medicare.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We maintain our principal executive office at 3660 Grandview Parkway, Birmingham, Alabama. We occupy those office premises under a long-term lease which expires in 2018 and includes options for us, at our discretion, to renew the lease for up to ten years in total beyond that date.

In addition to our principal executive office, as of December 31, 2014, we leased or owned through various consolidated entities 260 business locations to support our operations, including 136 locations leased by the Encompass Home Health and Hospice business ("Encompass") at the time we acquired it. Our hospital leases, which represent the largest portion of our rent expense, customarily have initial terms of 10 to 30 years. Most of our leases contain one or more options to extend the lease period for five additional years for each option. Our consolidated entities are generally responsible for property taxes, property and casualty insurance, and routine maintenance expenses, particularly in our leased hospitals. Other than our principal executive offices, no other individual property is materially important.

Encompass is based in Dallas, Texas where it leases office space for corporate and administrative functions. The remaining Encompass locations are in the localities served by that business and are subject to relatively small space leases, approximately 3,200 square feet on average. Those space leases are typically less than five years in term.

The following table sets forth information regarding our hospital properties (excluding the one hospital that has 41 licensed beds and operates as a joint venture which we account for using the equity method of accounting) and our Encompass locations as of December 31, 2014:

State	Licensed Beds	Number of Hospitals				Encompass Locations
		Building and Land Owned	Building Owned and Land Leased	Building and Land Leased	Total	
Alabama *	383	1	3	2	6	—
Arizona	335	1	1	3	5	—
Arkansas	267	2	1	1	4	—
California	114	1	—	1	2	—
Colorado	104	1	—	1	2	5
Connecticut	—	—	—	—	—	1
Delaware	34	—	1	—	1	—
Florida *	887	9	1	2	12	5
Georgia*	108	2 (1)	—	—	2	—
Idaho	—	—	—	—	—	10
Illinois *	61	—	1	—	1	—
Indiana	85	—	—	1	1	—
Kansas	242	1	—	2	3	7
Kentucky *	80	1	1	—	2	—
Louisiana	47	1	—	—	1	—
Maine *	100	—	—	1	1	—
Maryland *	54	1	—	—	1	—
Massachusetts *	163	2	—	—	2	1
Missouri*	156	—	2	—	2	—
Nevada	219	2	—	1	3	—
New Hampshire *	50	—	1	—	1	—
New Jersey *	199	1	1	1	3	—
New Mexico	87	1	—	—	1	6
Ohio	60	—	—	1	1	—
Oklahoma	—	—	—	—	—	18
Oregon	—	—	—	—	—	1
Pennsylvania	734	5	—	4	9	—
Puerto Rico*	72	—	—	2	2	—
South Carolina *	338	1	4	—	5	—
Tennessee *	395	4	3	—	7	—
Texas	1,083	12	2	1	15	62
Utah	84	1	—	—	1	11
Virginia *	286	2	1	3	6	9
West Virginia *	268	1	3	—	4	—
	7,095	53	26	27	106	136 (2)

* Hospital certificate of need state or U.S. territory

(1) The inpatient rehabilitation hospitals in Augusta and Newnan, Georgia, are parties to industrial development bond financings that reduce the *ad valorem* taxes payable by each hospital. In connection with each of these bond structures, title to the related property is held by the local development authority. We lease the related hospital property and hold the bonds issued by that authority, the payment on which equals the amount payable under the lease. We may terminate each bond financing and the associated lease at any time at our option without penalty, and fee title to the related hospital property will return to us.

(2) This total includes (1) the Encompass corporate office, (2) 107 locations where adult home health services are provided, (3) 8 locations where pediatric home health services are provided, and (4) 20 locations where hospice services are provided.

Our principal executive office, hospitals, and other properties are suitable for their respective uses and are, in all material respects, adequate for our present needs. Information regarding the utilization of our licensed beds and other operating statistics can be found in Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations.*

Item 3. Legal Proceedings

Information relating to certain legal proceedings in which we are involved is included in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements, which is incorporated herein by reference.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information

Shares of our common stock trade on the New York Stock Exchange under the ticker symbol "HLS." The following table sets forth the high and low sales prices per share for our common stock as reported on the NYSE from January 1, 2013 through December 31, 2014.

	High	Low
2013		
First Quarter	$ 26.40	$ 21.53
Second Quarter	30.95	25.07
Third Quarter	36.52	28.70
Fourth Quarter	37.01	32.97
2014		
First Quarter	$ 35.98	$ 29.82
Second Quarter	37.68	33.05
Third Quarter	42.41	35.29
Fourth Quarter	42.00	36.10

Holders

As of February 17, 2015, there were 87,488,636 shares of HealthSouth common stock issued and outstanding, net of treasury shares, held by approximately 9,006 holders of record.

Dividends

On October 15, 2013, we paid the first cash dividend, $0.18 per share, on our common stock, and we paid the same per share dividend quarterly through July 15, 2014. On July 17, 2014, our board of directors approved an increase in our quarterly dividend and declared a cash dividend of $0.21 per share that was paid on October 15, 2014 to stockholders of record on October 1, 2014. On January 15, 2015, we paid a cash dividend on our common stock of $0.21 per share to stockholders of record as of the close of business on January 2, 2015. We expect quarterly dividends to continue to be paid in January, April, July, and October. However, the actual declaration of any future cash dividends, and the setting of record and payment dates as well as the per share amounts, will be at the discretion of our board each quarter after consideration of various factors, including our capital position and alternative uses of funds.

The terms of our credit agreement allow us to declare and pay cash dividends on our common stock so long as: (1) we are not in default under our credit agreement and (2) our senior secured leverage ratio remains less than or equal to 1.75x. The terms of our senior note indenture allow us to declare and pay cash dividends on our common stock so long as (1) we are not in default, (2) the consolidated coverage ratio (as defined in the indenture) exceeds 2x or we are otherwise allowed under the indenture to incur debt, and (3) we have capacity under the indenture's restricted payments covenant to declare and pay dividends. We believe we currently have adequate capacity under these covenants to pursue the dividend strategy described in this report for the foreseeable future based on the capacity as of December 31, 2014 and anticipated restricted payments. See Note 8, *Long-term Debt,* to the accompanying consolidated financial statements.

Our preferred stock generally provides for the payment of cash dividends subject to certain limitations. See Note 10, *Convertible Perpetual Preferred Stock*, to the accompanying consolidated financial statements. Our credit agreement and our senior note indenture do not limit the payment of dividends on the preferred stock.

Recent Sales of Unregistered Securities

None.

Securities Authorized for Issuance Under Equity Compensation Plans

The information required by Item 201(d) of Regulation S-K is provided under Item 12, *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters*, "Equity Compensation Plans," and incorporated here by reference.

Purchases of Equity Securities

The following table summarizes our repurchases of equity securities during the three months ended December 31, 2014:

Period	Total Number of Shares (or Units) Purchased	Average Price Paid per Share (or Unit) ($)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares That May Yet Be Purchased Under the Plans or Programs[1]
October 1 through October 31, 2014	953 [2]	$ 37.02	—	206,944,707
November 1 through November 30, 2014	868 [3]	$ 40.27	—	206,944,707
December 1 through December 31, 2014	—	—	—	206,944,707
Total	1,821	38.57	—	

(1) On October 28, 2013, we announced our board of directors authorized the repurchase of up to $200 million of our common stock. On February 14, 2014, our board of directors approved an increase in this common stock repurchase authorization from $200 million to $250 million. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. Subject to certain terms and conditions, including a maximum price per share and compliance with federal and state securities and other laws, the repurchases may be made from time to time in open market transactions, privately negotiated transactions, or other transactions, including trades under a plan established in accordance with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended.

(2) These shares were purchased pursuant to previous elections by one or more members of our board of directors to participate in our Directors' Deferred Stock Investment Plan. This plan is a nonqualified deferral plan allowing non-employee directors to make advance elections to defer a fixed percentage of their director fees. The plan administrator acquires the shares in the open market which are then held in a rabbi trust. The plan provides that dividends paid on the shares held for the accounts of the directors will be reinvested in shares of our common stock which will also be held in the trust. The directors' rights to all shares in the trust are nonforfeitable, but the shares are only released to the directors after departure from our board.

(3) An employee tendered 602 shares as payment of tax liability incident to the vesting of previously awarded shares of restricted stock. The remaining shares were purchased pursuant to previous elections by one or more members of our board of directors to participate in our Directors' Deferred Stock Investment Plan described above.

Company Stock Performance

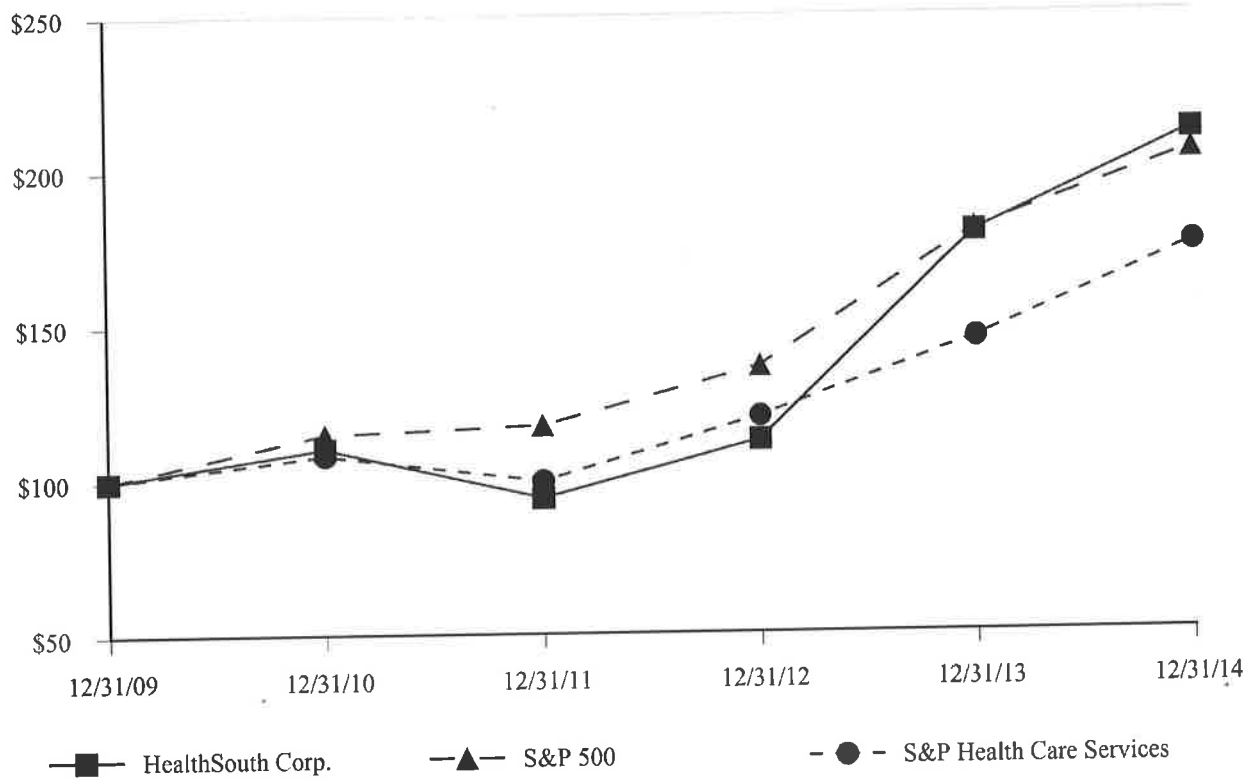
Set forth below is a line graph comparing the total returns of our common stock, the Standard & Poor's 500 Index ("S&P 500"), and the S&P Health Care Services Select Industry Index ("SPSIHP"), an equal-weighted index of at least 22 companies in healthcare services that are also part of the S&P Total Market Index and subject to float-adjusted market capitalization and liquidity requirements. Our compensation committee has in prior years used the SPSIHP as a benchmark for a portion of the awards under our long-term incentive program. The graph assumes $100 invested on December 31, 2009 in our common stock and each of the indices. The returns below assume reinvestment of dividends paid on the related common stock. We have paid a quarterly cash dividend on our common stock since October 2013.

The information contained in the performance graph shall not be deemed "soliciting material" or to be "filed" with the SEC nor shall such information be deemed incorporated by reference into any future filing under the Securities Act of 1933 or the Securities Exchange Act of 1934, except to the extent we specifically incorporate it by reference into such filing.

The comparisons in the graph below are based upon historical data and are not indicative of, nor intended to forecast, future performance of HealthSouth's common stock. Research Data Group, Inc. provided us with the data for the indices presented below. We assume no responsibility for the accuracy of the indices' data, but we are not aware of any reason to doubt its accuracy.

COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN

Among HealthSouth Corporation, the S&P 500 Index, and the S&P Health Care Services Select Industry Index



	For the Year Ended December 31,					
	Base Period	Cumulative Total Return				
Company/Index Name	2009	2010	2011	2012	2013	2014
HealthSouth	100.00	110.34	94.14	112.47	179.42	211.52
Standard & Poor's 500 Index	100.00	115.06	117.49	136.30	180.44	205.14
S&P Health Care Services Select Industry Index	100.00	108.13	99.74	120.07	144.94	175.09

Item 6. Selected Financial Data

We derived the selected historical consolidated financial data presented below for the years ended December 31, 2014, 2013, and 2012 from our audited consolidated financial statements and related notes included elsewhere in this filing. We derived the selected historical consolidated financial data presented below for the years ended December 31, 2011 and 2010, from our consolidated financial statements and related notes included in our Form 10-K for the year ended December 31, 2011. Refer to Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, and the notes to the accompanying consolidated financial statements for additional information regarding the financial data presented below, including matters that might cause this data not to be indicative of our future financial position or results of operations.

	For the Year Ended December 31,				
	2014	2013	2012	2011	2010
	(In Millions, Except per Share Data)				
Statement of Operations Data: [1]					
Net operating revenues	$ 2,405.9	$ 2,273.2	$ 2,161.9	$ 2,026.9	$ 1,877.6
Operating earnings [2]	418.4	435.7	378.7	351.4	295.9
Provision for income tax expense (benefit) [3]	110.7	12.7	108.6	37.1	(740.8)
Income from continuing operations	276.2	382.5	231.4	205.8	930.7
Income (loss) from discontinued operations, net of tax [4]	5.5	(1.1)	4.5	48.8	9.1
Net income	281.7	381.4	235.9	254.6	939.8
Less: Net income attributable to noncontrolling interests	(59.7)	(57.8)	(50.9)	(45.9)	(40.8)
Net income attributable to HealthSouth	222.0	323.6	185.0	208.7	899.0
Less: Convertible perpetual preferred stock dividends	(6.3)	(21.0)	(23.9)	(26.0)	(26.0)
Less: Repurchase of convertible perpetual preferred stock [5]	—	(71.6)	(0.8)	—	—
Net income attributable to HealthSouth common shareholders	$ 215.7	$ 231.0	$ 160.3	$ 182.7	$ 873.0
Weighted average common shares outstanding: [6]					
Basic	86.8	88.1	94.6	93.3	92.8
Diluted	100.7	102.1	108.1	109.2	108.5
Earnings per common share:					
Basic earnings per share attributable to HealthSouth common shareholders:					
Continuing operations	$ 2.40	$ 2.59	$ 1.62	$ 1.39	$ 9.20
Discontinued operations	0.06	(0.01)	0.05	0.52	0.10
Net income	$ 2.46	$ 2.58	$ 1.67	$ 1.91	$ 9.30
Diluted earnings per share attributable to HealthSouth common shareholders:					
Continuing operations	$ 2.24	$ 2.59	$ 1.62	$ 1.39	$ 8.20
Discontinued operations	0.05	(0.01)	0.05	0.52	0.08
Net income	$ 2.29	$ 2.58	$ 1.67	$ 1.91	$ 8.28
Cash dividends per common share [7]	$ 0.78	$ 0.36	$ —	$ —	$ —
Amounts attributable to HealthSouth:					
Income from continuing operations	$ 216.5	$ 324.7	$ 180.5	$ 158.8	$ 889.8
Income (loss) from discontinued operations, net of tax	5.5	(1.1)	4.5	49.9	9.2
Net income attributable to HealthSouth	$ 222.0	$ 323.6	$ 185.0	$ 208.7	$ 899.0

	As of December 31,				
	2014	2013	2012	2011	2010
	(In Millions)				
Balance Sheet Data: [1]					
Working capital	$ 322.3	$ 268.8	$ 335.9	$ 178.4	$ 111.0
Total assets [8]	3,408.8	2,534.4	2,424.2	2,271.6	2,372.5
Long-term debt, including current portion [5] [8]	2,131.6	1,517.5	1,253.5	1,254.7	1,511.3
Convertible perpetual preferred stock [5]	93.2	93.2	342.2	387.4	387.4
HealthSouth shareholders' equity (deficit)	473.2	344.6	291.0	116.4	(85.8)

(1) As discussed in Note 2, *Business Combinations*, to the accompanying consolidated financial statements, we acquired the Encompass Home Health and Hospice business ("Encompass") of EHHI Holdings, Inc. on December 31, 2014. Because the acquisition took place on December 31, 2014, our consolidated results of operations do not include any results of operations from Encompass. Assets acquired, liabilities assumed, and redeemable noncontrolling interests were recorded at their estimated fair values as of the acquisition date.

(2) We define operating earnings as income from continuing operations attributable to HealthSouth before (1) loss on early extinguishment of debt; (2) interest expense and amortization of debt discounts and fees; (3) other income; (4) loss on interest rate swaps; and (5) income tax expense or benefit.

(3) For information related to our *Provision for income tax expense (benefit)*, see Item 7, *Management's Discussion and Analysis of Financial Condition and Results of Operations*, and Note 16, *Income Taxes*, to the accompanying consolidated financial statements. During the second quarter of 2013, we entered into closing agreements with the IRS that settled federal income tax matters related to the previous restatement of our 2000 and 2001 financial statements, as well as certain other tax matters, through December 31, 2008 and recorded a net income tax benefit of approximately $115 million. During the fourth quarter of 2010, we determined it is more likely than not a substantial portion of our deferred tax assets will be realized in the future and decreased our valuation allowance by $825.4 million through our *Provision for income tax benefit* in our consolidated statement of operations.

(4) *Income from discontinued operations, net of tax* in 2011 included post-tax gains from the sale of five long-term acute care hospitals and a settlement related to a previously disclosed audit of unclaimed property.

(5) During the fourth quarter of 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock. See Note 8, *Long-term Debt* and Note 10, *Convertible Perpetual Preferred Stock*, to the accompanying consolidated financial statements.

(6) During 2014, we repurchased 1.3 million shares of our common stock in the open market for $43.1 million. In the first quarter of 2013, we completed a tender offer for our common stock whereby we repurchased approximately 9.1 million shares. See Note 17, *Earnings per Common Share*, to the accompanying consolidated financial statements.

(7) During the third quarter of 2013, our board of directors approved the initiation of a quarterly cash dividend on our common stock of $0.18 per share. In July 2014, our board of directors approved an increase in our quarterly cash dividend to $0.21 per share. See Note 17, *Earnings per Common Share*, to the accompanying consolidated financial statements.

(8) On December 31, 2014, we acquired Encompass. The total cash consideration delivered at closing was $695.5 million. We funded the cash purchase price in the acquisition entirely with draws under the revolving and expanded term loan facilities of our credit agreement. See Note 2, *Business Combinations*, and Note 8, *Long-term Debt*, to the accompanying consolidated financial statements.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A") should be read in conjunction with the accompanying consolidated financial statements and related notes. This MD&A is designed to provide the reader with information that will assist in understanding our consolidated financial statements, the changes in certain key items in those financial statements from year to year, and the primary factors that accounted for those changes, as well as how certain accounting principles affect our consolidated financial statements. See "Cautionary Statement

Regarding Forward-Looking Statements" on page ii of this report for a description of important factors that could cause actual results to differ from expected results. See also Item 1A, *Risk Factors*.

Executive Overview

Our Business

With the acquisition of Encompass discussed below, HealthSouth is one of the nation's largest providers of post-acute healthcare services, offering both facility-based and home-based post-acute services in 33 states and Puerto Rico through its network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies.

As of December 31, 2014, we operated 107 inpatient rehabilitation hospitals (including one hospital that operates as a joint venture which we account for using the equity method of accounting). While our national network of inpatient hospitals stretches across 29 states and Puerto Rico, our inpatient hospitals are concentrated in the eastern half of the United States and Texas. In addition to HealthSouth hospitals, we manage three inpatient rehabilitation units through management contracts. For additional information about our business, see Item 1, *Business*.

Encompass Acquisition

On December 31, 2014, we completed the previously announced acquisition of EHHI Holdings, Inc. ("EHHI") and its Encompass Home Health and Hospice business ("Encompass"). Encompass is the nation's fifth largest provider of Medicare-certified skilled home health services. In the acquisition, we acquired, for cash, all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to HealthSouth Home Health Holdings, Inc. ("Holdings"), a subsidiary of HealthSouth and now indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. These certain sellers were members of Encompass management, including April Anthony, the Chief Executive Officer of Encompass. These sellers contributed a portion of their shares of common stock of EHHI, valued at approximately $64.5 million, in exchange for shares of common stock of Holdings. As a result of that contribution, they hold approximately 16.7% of the outstanding common stock of Holdings, while HealthSouth owns the remainder. In addition, Ms. Anthony and certain other employees of Encompass entered into amended and restated employment agreements, each agreement having an initial term of three years.

We funded the cash purchase price in the acquisition entirely with draws under the revolving and expanded term loan facilities of our credit agreement. The total cash consideration delivered at closing was $695.5 million.

Encompass operates in 135 locations across 12 states and has approximately 4,900 employees making more than 2.1 million patient visits annually. For the year ended December 31, 2014, Encompass had total revenues of approximately $369 million, which are not included in the accompanying consolidated statement of operations.

Encompass provides:

- home health services - a comprehensive range of Medicare-certified home nursing services to adult patients in need of care. These services include, among others, skilled nursing, physical, occupational and speech therapy, medical social work, and home health aide services. Encompass also provides specialized home care services in Texas and Kansas for pediatric patients with severe medical conditions. Encompass' home health services have historically represented a substantial portion of its revenues. For the year ended December 31, 2014, these services represented approximately 94% of Encompass' total revenues.

- hospice services - primarily in-home services to terminally ill patients and their families to address the patients' physical needs, including pain control and symptom management, and to provide emotional and spiritual support. For the year ended December 31, 2014, these services represented approximately 6% of Encompass' total revenues.

We believe Encompass will provide us with a high-quality, scalable asset that is capable of participating in the consolidation of the highly fragmented home health industry. Encompass has demonstrated an ability to acquire under-performing operations and incorporate them into its existing platform. As part of HealthSouth, we believe Encompass will be able to consider more numerous and significant home health acquisition opportunities given our strong cash flows from operations and our access to capital. We also believe this acquisition will further our long-term growth strategy of expanding into post-acute services that complement our core business of operating inpatient rehabilitation hospitals. Specifically, we believe the acquisition of Encompass will enhance our ability to provide a continuum of facility-based and home-based post-acute services to our patients and their families, which we believe will become increasingly important as coordinated care delivery models, such as accountable care organizations ("ACOs") and bundled payment arrangements, become more

prevalent. We intend to transition our existing 25 hospital-based home health operations to the Encompass platform in 2015. Home health and hospice will represent a separate operating segment for us going forward.

See Item 1, *Business*, and Item 1A, *Risk Factors*, of this report, Note 2, *Business Combinations*, and Note 8, *Long-term Debt*, to the accompanying consolidated financial statements, and the "Results of Operations" and "Liquidity and Capital Resources" sections of this Item.

2014 Overview

Our 2014 strategy focused on the following priorities:

- continuing to provide high-quality, cost-effective care to patients in our existing markets;
- achieving organic growth at our existing hospitals;
- expanding our services to more patients who require inpatient rehabilitative services by constructing and acquiring new hospitals in new markets;
- continuing our shareholder value-enhancing strategies such as common stock dividends and repurchases of our common stock; and
- positioning the Company for continued success in the evolving healthcare delivery system. This preparation includes continuing the installation of our electronic clinical information system which allows for interfaces with all major acute care electronic medical record systems and health information exchanges, participating in bundling projects and ACOs, and evaluating potential service line expansions via acquisitions.

During 2014, discharge growth of 3.5% coupled with a 3.1% increase in net patient revenue per discharge generated 6.7% growth in net patient revenue from our hospitals compared to 2013. Discharge growth was comprised of 2.2% growth from new stores and a 1.3% increase in same-store discharges. Our quality and outcome measures, as reported through the Uniform Data System for Medical Rehabilitation (the "UDS"), remained well above the average for hospitals included in the UDS database, and they did so while we continued to increase our market share throughout 2014. Not only did our hospitals treat more patients and enhance outcomes, they did so in a highly cost-effective manner. See the "Results of Operations" section of this Item.

Likewise, our growth efforts continued to yield positive results in 2014. Specifically, we:

- acquired an additional 30% equity interest from UMass Memorial Health Care, our joint venture partner in Fairlawn Rehabilitation Hospital ("Fairlawn") in Worcester, Massachusetts in June 2014. This transaction increased our ownership interest from 50% to 80% and resulted in a change in accounting for this hospital from the equity method of accounting to a consolidated entity;
- began accepting patients at our newly built, 50-bed inpatient rehabilitation hospital in Altamonte Springs, Florida in October 2014;
- created, in October 2014, a joint venture with Memorial Health to own and operate a 50-bed inpatient rehabilitation hospital in Savannah, Georgia. Initially, this hospital will operate in the current location of Memorial Health's 50-bed Rehabilitation Institute on Memorial University Medical Center's campus. The joint venture plans to build a new, 50-bed replacement inpatient rehabilitation hospital, which is expected to be completed in early 2016. We expect to begin operating the inpatient rehabilitation hospital at Memorial University Medical Center in the first half of 2015;
- acquired Quillen Rehabilitation Hospital, a 26-bed inpatient rehabilitation hospital in Johnson City, Tennessee, in November 2014 through a joint venture with Mountain States Health Alliance;
- began accepting patients at our newly built, 50-bed inpatient rehabilitation hospital in Newnan, Georgia in December 2014;
- began accepting patients at our newly built, 34-bed inpatient rehabilitation hospital in Middletown, Delaware in December 2014;

- continued our capacity expansions by adding 51 new beds to existing hospitals; and
- continued development of the following de novo hospitals:

Location	# of Beds	Actual / Expected Construction Start Date	Expected Operational Date
Franklin, Tennessee	40	Q4 2014	Q4 2015
Modesto, California	50	Q1 2015	Q2 2016
Murrieta, California*	50	Q3 2016	Q4 2017

*In August 2014, we acquired land and began the design and permitting process to build an inpatient rehabilitation hospital.

We also continued our shareholder value-enhancing strategies in 2014. Namely, we:

- increased our board-approved stock repurchase authorization from $200 million to $250 million in February 2014 and repurchased 1.3 million shares of our common stock in the open market for $43.1 million during the first and second quarters of 2014, leaving approximately $207 million remaining under this repurchase authorization and
- paid approximately $66 million in cash dividends on our common stock and increased the quarterly cash dividend by 16.7% from $0.18 per share to $0.21 per share effective with the October 2014 dividend payment.

While continuing our shareholder value-enhancing strategies, we also took additional steps to increase the strength and flexibility of our balance sheet. Specifically, we:

- amended our credit agreement in September and December 2014 to, among other things, add $450 million of term loan facility capacity, permit unlimited restricted payments so long as the senior secured leverage ratio remains less than or equal to 1.75x, and extend the revolver maturity to September 2019;
- redeemed the outstanding principal amount, or approximately $271 million in principal, of our 7.25% Senior Notes due 2018 in October 2014 using the net proceeds from an additional $175 million offering of our existing 5.75% Senior Notes due 2024, a $75 million draw under our term loan facilities, and cash on hand;
- redeemed approximately $25 million of the outstanding principal amount of our existing 7.75% Senior Notes due 2022 in December 2014. This optional redemption represented 10% of the outstanding principal amount of the notes at a price of 103%, which resulted in a total cash outlay of approximately $26 million; and
- purchased the real estate previously subject to a lease associated with our hospital in San Antonio, Texas.

For additional information regarding these actions, see Note 8, *Long-term Debt*, to the accompanying consolidated financial statements and the "Liquidity and Capital Resources" section of this Item.

Business Outlook

We believe our business outlook remains positive for two primary reasons. First, demographic trends, such as population aging, should increase long-term demand for facility-based and home-based post-acute services. While we treat patients of all ages, most of our patients are 65 and older, and the number of Medicare enrollees is expected to grow approximately 3% per year for the foreseeable future. We believe the demand for facility-based and home-based post-acute services will continue to increase as the U.S. population ages and life expectancies increase.

Second, we are an industry leader in this growing sector. As the nation's largest owner and operator of inpatient rehabilitation hospitals, we believe we differentiate ourselves from our competitors based on our broad platform of clinical expertise, the quality of our clinical outcomes, the sustainability of best practices, our financial strength, and the application of rehabilitative technology. With the recent acquisition of Encompass, we are the fifth largest provider of Medicare-certified skilled home health services, and we look forward to combining our strengths as operators of inpatient rehabilitation hospitals with those of a proven home health and hospice provider that offers exceptional home-based patient care in a cost efficient manner.

We have invested considerable resources into clinical and management systems and protocols that have allowed us to consistently produce high-quality outcomes for our patients while continuing to contain cost growth. Our proprietary hospital management reporting system aggregates data from each of our key business systems into a comprehensive reporting package used by the management teams in our hospitals, as well as executive management, and allows them to analyze data and trends and create custom reports on a timely basis. Our commitment to technology also includes the on-going implementation of our rehabilitation-specific electronic clinical information system. As of December 31, 2014, we had installed this system in 58 of our 107 hospitals. We believe this system will improve patient care and safety, enhance staff recruitment and retention, and set the stage for connectivity with other providers and health information exchanges. Encompass also utilizes information technology to enhance patient care and manage costs. Specifically, Encompass utilizes Homecare Homebase℠, a comprehensive information platform that allows home health providers to process clinical, compliance, and marketing information as well as analyze data and trends for management purposes using custom reports on a timely basis. This allows Encompass to manage the entire patient work flow and provide valuable data for health systems, payors, and ACO partners. Encompass is currently party to one newly formed ACO serving 20,000 patients and is exploring several other participation opportunities.

We believe these factors align with our strengths in, and focus on, post-acute services. In addition, we believe we can address the demand for facility-based and home-based post-acute services in markets where we currently do not have a presence by constructing or acquiring new hospitals and by acquiring home health and hospice agencies in that highly fragmented industry.

Longer-term, the nature and timing of the transformation of the current healthcare system to coordinated care delivery and payment models is uncertain and will likely remain so for some time, as the development of new delivery and payment systems will almost certainly require significant time and resources. Furthermore, many of the alternative approaches being explored may not work as intended. However, as outlined in the "Key Challenges—Changes to Our Operating Environment Resulting from Healthcare Reform" section below, our goal is to position the Company in a prudent manner to be responsive to industry shifts. We have been disciplined in creating a capital structure that is flexible with no significant debt maturities prior to 2019. We have invested in our core business and created an infrastructure that enables us to provide high-quality care on a cost-effective basis. Our balance sheet remains strong. We have significant availability under our revolving credit facility, and we continue to generate strong cash flows from operations. Importantly, we have flexibility with how we choose to invest our cash and return value to shareholders, including bed additions, de novos, acquisitions of inpatient rehabilitation hospitals, home health agencies, and hospice agencies, common stock dividends, repurchases of our common and preferred stock, and repayments of long-term debt.

For these and other reasons, we believe we will be able to adapt to changes in reimbursement, sustain our business model, and grow through acquisition and consolidation opportunities as they arise.

Key Challenges

The healthcare industry is facing many well-publicized regulatory and reimbursement challenges. The industry is also facing uncertainty associated with the efforts, primarily arising from initiatives included in the 2010 Healthcare Reform Laws (as defined in Item 1, *Business*, "Regulatory and Reimbursement Challenges") to identify and implement workable coordinated care delivery models. Successful healthcare providers are those who provide high-quality, cost-effective care and have the ability to adjust to changes in the regulatory and operating environments. We believe we have the necessary capabilities — scale, infrastructure, balance sheet, and management — to adapt to changes and continue to succeed in a highly regulated industry, and we have a proven track record of doing so.

As we continue to execute our business plan, the following are some of the challenges we face:

- Operating in a Highly Regulated Industry. We are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These rules and regulations have affected, or could in the future affect, our business activities by having an impact on the reimbursement we receive for services provided or the costs of compliance, mandating new documentation standards, requiring additional licensure or certification of our hospitals, regulating our relationships with physicians and other referral sources, regulating the use of our properties, and limiting our ability to enter new markets or add new beds to existing hospitals. Ensuring continuous compliance with extensive laws and regulations is an operating requirement for all healthcare providers.

  We have invested, and will continue to invest, substantial time, effort, and expense in implementing and maintaining training programs as well as internal controls and procedures designed to ensure regulatory compliance, and we are committed to continued adherence to these guidelines. More specifically, because

Medicare comprises a significant portion of our *Net operating revenues*, it is important for us to remain compliant with the laws and regulations governing the Medicare program and related matters including anti-kickback and anti-fraud requirements. If we were unable to remain compliant with these regulations, our financial position, results of operations, and cash flows could be materially, adversely impacted.

As discussed in Item 1, *Business*, "Sources of Revenues," in connection with United States Centers for Medicare and Medicaid Services ("CMS") approved and announced Recovery Audit Contractor ("RAC") audits related to inpatient rehabilitation facilities ("IRFs"), we have received requests to review certain patient files for discharges occurring from 2010 to 2014. To date, the Medicare payments that are subject to these audit requests represent less than 1% of our Medicare patient discharges during those years, and not all of these patient file requests have resulted in payment denial determinations by the RACs. Because we have confidence in the medical judgment of both the referring and the admitting physicians who assess the treatment needs of their patients, we have appealed substantially all RAC denials arising from these audits.

The contracts awarded to RACs by CMS were set to expire in February 2014, but they have been extended and modified pending finalization of new contracts. In late February 2014, CMS announced it would pause the operations of the current RACs until new contracts are awarded, meaning that hospitals would not receive any new requests from RACs until that time. Legal challenges to the contract award process have delayed finalizing the new contracts longer than expected, and as a result, CMS modified the existing RAC contracts to allow some RAC reviews to be restarted on a limited basis. Additionally, on December 30, 2014, CMS announced the beginning of a new contract for the RAC assigned to audit payments for home health and hospice services, which has subsequently been delayed by another challenge. Once the new contracts are in place, whether for IRFs or home health and hospice agencies, the associated RACs will be able to audit claims for dates of service during the time period covered by the pause in RAC operations. We cannot predict when the legal challenges to the new contracts will be resolved or when CMS will otherwise finalize the new RAC contracts. While we make provisions for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by Medicare Administrative Contractors ("MACs"), we cannot provide assurance as to our future success in the resolution of these and future disputes, nor can we predict or estimate the scope or number of denials that ultimately may be received.

Another challenge relates to reduced Medicare reimbursement, which is also discussed in Item 1A, *Risk Factors*. Unless the United States Congress acts to change or eliminate it, sequestration, which began affecting payments received after April 1, 2013, will continue to result in a 2% decrease to reimbursements otherwise due from Medicare, after taking into consideration other changes to reimbursement rates such as market basket updates.

Additionally, concerns held by federal policymakers about the federal deficit, national debt levels, and reforming the sustainable growth rate formula used to pay physicians who treat Medicare beneficiaries (the so called "Doc Fix") could result in enactment of further federal spending reductions, further entitlement reform legislation affecting the Medicare program, and/or further reductions to provider payments. Likewise, issues related to the federal budget or the unwillingness to raise the statutory cap on the federal government's ability to issue debt, also referred to as the "debt ceiling," may have a significant impact on the economy and indirectly on our results of operations and financial position. We cannot predict what alternative or additional deficit reduction initiatives, Medicare payment reductions, or post-acute care reforms, if any, will ultimately be enacted into law, or the timing or effect any such initiatives or reductions will have on us. If enacted, such initiatives or reductions would likely be challenging for all providers, would likely have the effect of limiting Medicare beneficiaries' access to healthcare services, and could have an adverse impact on our financial position, results of operations, and cash flows. However, we believe our efficient cost structure coupled with the steps we have taken to reduce our debt and corresponding debt service obligations should allow us to absorb, adjust to, or mitigate any potential initiative or reimbursement reductions more easily than most other post-acute providers.

See also Item 1, *Business*, "Sources of Revenues" and "Regulation," and Item 1A, *Risk Factors*, to this report and Note 18, *Contingencies and Other Commitments*, "Governmental Inquiries and Investigations," to the accompanying consolidated financial statements.

- Changes to Our Operating Environment Resulting from Healthcare Reform. Our challenges related to healthcare reform are discussed in Item 1, *Business*, "Sources of Revenues," and Item 1A, *Risk Factors*.

  Many provisions within the 2010 Healthcare Reform Laws have impacted, or could in the future impact, our business. Most notably for us are the reductions to our hospitals' annual market basket updates, including productivity adjustments, mandated reductions to home health and hospice Medicare reimbursements, and future

payment reforms such as ACOs and bundled payments. Given the complexity and the number of changes in the 2010 Healthcare Reform Laws, we cannot predict their ultimate impact.

On July 31, 2014, CMS released its notice of final rulemaking for fiscal year 2015 (the "2015 Rule") for IRFs under the prospective payment system ("IRF-PPS"). The 2015 Rule will implement a net 2.2% market basket increase effective for discharges between October 1, 2014 and September 30, 2015, calculated as follows:

Market basket update	2.9%
Healthcare reform reduction	20 basis points
Productivity adjustment	50 basis points

The 2015 Rule also includes other changes that impact our hospital-by-hospital base rate for Medicare reimbursement. Such changes include, but are not limited to, freezing the IRF-PPS facility-level rural adjustment factor, low-income patient factor, and teaching status adjustment factor and updating the outlier fixed loss threshold. Based on our analysis which utilizes, among other things, the acuity of our patients over the 12-month period prior to the rule's release and incorporates other adjustments included in the rule, we believe the 2015 Rule will result in a net increase to our Medicare payment rates of approximately 2.3% effective October 1, 2014, prior to the impact of sequestration.

Additionally, the final rule introduces, beginning on October 1, 2015, a new data collection requirement that will capture the minutes and mode (individual, group, concurrent, or co-treatment) of therapy by specialty. CMS plans to use this data to potentially support future rule making in this area. Further, the final rule includes revisions to the list of codes used by CMS to presumptively test compliance with the 60% Rule. The post-amputation codes that CMS plans to eliminate represented approximately 0.5% of our 2013 Medicare discharges. CMS also will require reporting of two new quality measures, beginning January 1, 2015, and will conduct validation audits to ensure the completeness and accuracy of the quality data submitted.

On October 30, 2014, CMS released the calendar year 2015 final rule for home health agencies under the prospective payment system ("HH-PPS"). CMS estimates the rule will cut Medicare payments to home health agencies by 0.3% in 2015. Specifically, while the rule provides for a market basket update of 2.6%, that update is offset by a 2.4% rebasing adjustment reduction (the second year of a four-year phase-in) and a productivity adjustment reduction of 50 basis points. We believe this final rule will result in a net decrease to Encompass' Medicare payment rates of approximately 1.3% in calendar year 2015 before sequestration.

The final rule also addresses a number of policy proposals. Notably, CMS is modifying the home health face-to-face encounter documentation requirements, including eliminating the narrative as part of the certification of eligibility and providing more flexibility in procedures for obtaining documentation supporting patient eligibility. CMS also discusses comments it received on a potential home health agency value-based purchasing model, under which CMS would test whether payment incentives would lead to higher quality of care for beneficiaries. CMS is considering testing such a model beginning in 2016. Additional details will be provided in future rulemaking.

The healthcare industry in general is facing uncertainty associated with the efforts, primarily arising from initiatives included in the 2010 Healthcare Reform Laws, to identify and implement workable coordinated care delivery models. In a coordinated care delivery model, hospitals, physicians, and other care providers work together to provide coordinated healthcare on a more efficient, patient-centered basis. These providers are then paid based on the overall value of the services they provide to a patient rather than the number of services they provide. While this is consistent with our goal and proven track record of being a high-quality, cost-effective provider, broad-based implementation of a new delivery model would represent a significant transformation for the healthcare industry. As the industry and its regulators explore this transformation, we are positioning the Company in preparation for whatever changes are ultimately made to the delivery system:

- We have a track record of successful partnerships with acute care providers. Thirty-two of our hospitals already operate as joint ventures with acute care hospitals, and we continue to pursue joint ventures as one of our growth initiatives. These joint ventures create an immediate link to an acute care system and position us to quickly and efficiently integrate our services in a coordinated care model.

- Our commitment to coordinated care is demonstrated and enhanced by the utilization of technology. Our hospital electronic clinical information system is capable of interfaces with all major acute care electronic

medical record systems and health information exchanges making communication easier across the continuum of healthcare providers. Our home health and hospice clinical information system utilizes a leading home care technology that manages the entire patient work flow. Importantly, we have the ability to use data from both systems to develop clinical protocol best practices.

- Our balance sheet is strong, and we have consistently strong free cash flows. We have no significant debt maturities prior to 2019, and we have significant liquidity under our revolving credit facility. In addition, we own the real estate associated with approximately 75% of our hospitals.

- We have a proven track record of being a high-quality, cost-effective provider. The FIM® Gains (a tool based on an 18-point assessment used to measure functional independence from admission to discharge) at our inpatient rehabilitation hospitals consistently exceed industry results, and the re-hospitalization rates at our home health agencies are lower than the national average. In addition, we have the scale and operating leverage to generate a low cost per discharge/visit.

- We are currently participating in several coordinated care delivery model initiatives and are exploring ACO participation in several others. We have 103 IRFs accepted into Phase 1 of Model 3 of the CMS Bundled Payments for Care Improvement ("BPCI") initiative. In January 2015, we began the process to seek acceptance into Phase 2 of this initiative for five IRFs with an April 2015 start date. We have another opportunity, should we choose to pursue it, to submit additional IRFs into Phase 2 in March 2015 with a July 2015 start date. Encompass has 10 agencies participating in Phase 2 of Model 3 of the BPCI initiative. In addition, Encompass has partnered with Premier PHC™, an ACO serving 20,000 Medicare patients.

Given the complexity and the number of changes in the 2010 Healthcare Reform Laws, we cannot predict their ultimate impact. In addition, the ultimate nature and timing of the transformation of the healthcare delivery system is uncertain, and will likely remain so for some time. We will continue to evaluate these laws and position the Company for this industry shift. Based on our track record, we believe we can adapt to these regulatory and industry changes. Further, we have engaged, and will continue to engage, actively in discussions with key legislators and regulators to attempt to ensure any healthcare laws or regulations adopted or amended promote our goal of high-quality, cost-effective care.

Additionally, in October 2014, the President signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014 (the "IMPACT Act"). The IMPACT Act was developed on a bi-partisan basis by the House Ways and Means and Senate Finance Committees and incorporated feedback from healthcare providers and provider organizations that responded to the Committees' solicitation of post-acute payment reform ideas and proposals. It directs the United States Department of Health and Human Services ("HHS"), in consultation with healthcare stakeholders, to implement standardized data collection processes for post-acute quality and outcome measures. Although the IMPACT Act does not specifically call for the development of a new post-acute payment system, we believe this act will lay the foundation for possible future post-acute payment policies that would be based on patients' medical conditions and other clinical factors rather than the setting where the care is provided. It will create additional data reporting requirements for our hospitals and home health agencies, and we expect to fully comply with these requirements. The precise details of these new reporting requirements, including timing and content, will be developed and implemented by CMS through the regulatory process that we expect will take place over the next several years. While we cannot quantify the potential financial effects of the IMPACT Act on HealthSouth, we believe any post-acute payment system that is data-driven and focuses on the needs and underlying medical conditions of post-acute patients ultimately will be a net positive for providers who offer high-quality, cost-effective care. However, it will likely take years for the related quality measures to be established, quality data to be gathered, standardized patient assessment data to be assembled and disseminated, and potential payment policies to be developed, tested, and promulgated. As the nation's largest owner and operator of inpatient rehabilitation hospitals and fifth largest provider of Medicare-certified skilled home health services, we will work with HHS, the Medicare Payment Advisory Commission, and other healthcare stakeholders on these initiatives.

- Maintaining Strong Volume Growth. Various factors, including competition and increasing regulatory and administrative burdens, may impact our ability to maintain and grow our hospital, home health, and hospice volumes. In any particular market, we may encounter competition from local or national entities with longer operating histories or other competitive advantages, such as acute care hospitals who provide post-acute services similar to ours or other post-acute providers with relationships with referring acute care hospitals or physicians. Aggressive payment review practices by Medicare contractors, aggressive enforcement of regulatory policies by government agencies, and restrictive or burdensome rules, regulations or statutes governing admissions practices

may lead us to not accept patients who would be appropriate for and would benefit from the services we provide. In addition, from time to time, we must get regulatory approval to expand our services and locations in states with certificate of need laws. This approval may be withheld or take longer than expected. In the case of new-store volume growth, the addition of hospitals, home health agencies, and hospice agencies to our portfolio also may be difficult and take longer than expected.

- Recruiting and Retaining High-Quality Personnel. See Item 1A, *Risk Factors*, for a discussion of competition for staffing, shortages of qualified personnel, and other factors that may increase our labor costs. Recruiting and retaining qualified personnel for our inpatient hospitals and home health and hospice agencies remain a high priority for us. We attempt to maintain a comprehensive compensation and benefits package that allows us to remain competitive in this challenging staffing environment while remaining consistent with our goal of being a high-quality, cost-effective provider of inpatient rehabilitative services.

See also Item 1, *Business*, and Item 1A, *Risk Factors*.

These key challenges notwithstanding, we have a strong business model, a strong balance sheet, and a proven track record of achieving strong financial and operational results. We are attempting to position the Company to respond to changes in the healthcare delivery system and believe we will be in a position to take advantage of any opportunities that arise as the industry moves to this new stage. We believe we are postured to continue to grow, adapt to external events, and create value for our shareholders in 2015 and beyond.

Results of Operations

As a result of the acquisition of Encompass on December 31, 2014, in the first quarter of 2015, management changed the way it manages and operates the consolidated reporting entity and modified the reports used by its chief operating decision maker to assess performance and allocate resources. These changes will require HealthSouth to revise its segment reporting from its historic presentation of only one reportable segment. Beginning in the first quarter of 2015, HealthSouth will manage its operations and disclose financial information using two reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. As part of this change in the first quarter of 2015, HealthSouth's historic 25 hospital-based home health agencies will be reclassified and included in the home health and hospice segment. These 25 home health agencies represented approximately $29 million of HealthSouth's consolidated *Net operating revenues* in 2014 and 2013.

Because the Encompass acquisition took place on December 31, 2014, our consolidated results of operations and the discussion that follows in this section do not include the 2014 results of operations of Encompass. Pro forma information regarding the combined entity is included in Note 2, *Business Combinations*, to the accompanying consolidated financial statements.

Payor Mix

During 2014, 2013, and 2012, we derived consolidated *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2014	2013	2012
Medicare	74.1%	74.5%	73.4%
Medicaid	1.8%	1.2%	1.2%
Workers' compensation	1.2%	1.2%	1.5%
Managed care and other discount plans, including Medicare Advantage	18.6%	18.5%	19.3%
Other third-party payors	1.8%	1.8%	1.8%
Patients	1.0%	1.1%	1.3%
Other income	1.5%	1.7%	1.5%
Total	100.0%	100.0%	100.0%

Our payor mix is weighted heavily towards Medicare. Our hospitals receive Medicare reimbursements under IRF-PPS. Under IRF-PPS, our hospitals receive fixed payment amounts per discharge based on certain rehabilitation impairment categories established by HHS. Under IRF-PPS, our hospitals retain the difference, if any, between the fixed payment from Medicare and their operating costs. Thus, our hospitals benefit from being cost-effective providers. For additional information regarding Medicare reimbursement, see the "Sources of Revenues" section of Item 1, *Business*.

As part of the Balanced Budget Act of 1997, Congress created a program of private, managed healthcare coverage for Medicare beneficiaries. This program has been referred to as Medicare Part C, or "Medicare Advantage." The program offers beneficiaries a range of Medicare coverage options by providing a choice between the traditional fee-for-service program (Under Medicare Parts A and B) or enrollment in a health maintenance organization, preferred provider organization, point-of-service plan, provider sponsor organization, or an insurance plan operated in conjunction with a medical savings account. Medicare Advantage revenues, included in the "managed care and other discount plans" category in the above table, represented approximately 8% of our total revenues during the years ended December 31, 2014, 2013, and 2012.

Our consolidated *Net operating revenues* consist primarily of revenues derived from patient care services. *Net operating revenues* also include other revenues generated from management and administrative fees and other nonpatient care services. These other revenues are included in "other income" in the above table.

Under IRF-PPS, hospitals are reimbursed on a "per discharge" basis. Thus, the number of patient discharges is a key metric utilized by management to monitor and evaluate our performance. The number of outpatient visits is also tracked in order to measure the volume of outpatient activity each period.

Our Results

From 2012 through 2014, our consolidated results of operations were as follows:

	For the Year Ended December 31,			Percentage Change	
	2014	2013	2012	2014 v. 2013	2013 v. 2012
		(In Millions)			
Net operating revenues	$ 2,405.9	$ 2,273.2	$ 2,161.9	5.8 %	5.1 %
Less: Provision for doubtful accounts	(31.6)	(26.0)	(27.0)	21.5 %	(3.7)%
Net operating revenues less provision for doubtful accounts	2,374.3	2,247.2	2,134.9	5.7 %	5.3 %
Operating expenses:					
Salaries and benefits	1,161.7	1,089.7	1,050.2	6.6 %	3.8 %
Hospital-related expenses:					
Other operating expenses	351.6	323.0	303.8	8.9 %	6.3 %
Occupancy costs	41.6	47.0	48.6	(11.5)%	(3.3)%
Supplies	111.9	105.4	102.4	6.2 %	2.9 %
General and administrative expenses	124.8	119.1	117.9	4.8 %	1.0 %
Depreciation and amortization	107.7	94.7	82.5	13.7 %	14.8 %
Government, class action, and related settlements	(1.7)	(23.5)	(3.5)	(92.8)%	571.4 %
Professional fees—accounting, tax, and legal	9.3	9.5	16.1	(2.1)%	(41.0)%
Total operating expenses	1,906.9	1,764.9	1,718.0	8.0 %	2.7 %
Loss on early extinguishment of debt	13.2	2.4	4.0	450.0 %	(40.0)%
Interest expense and amortization of debt discounts and fees	109.2	100.4	94.1	8.8 %	6.7 %
Other income	(31.2)	(4.5)	(8.5)	593.3 %	(47.1)%
Equity in net income of nonconsolidated affiliates	(10.7)	(11.2)	(12.7)	(4.5)%	(11.8)%
Income from continuing operations before income tax expense	386.9	395.2	340.0	(2.1)%	16.2 %
Provision for income tax expense	110.7	12.7	108.6	771.7 %	(88.3)%
Income from continuing operations	276.2	382.5	231.4	(27.8)%	65.3 %
Income (loss) from discontinued operations, net of tax	5.5	(1.1)	4.5	(600.0)%	(124.4)%
Net income	281.7	381.4	235.9	(26.1)%	61.7 %
Less: Net income attributable to noncontrolling interests	(59.7)	(57.8)	(50.9)	3.3 %	13.6 %
Net income attributable to HealthSouth	$ 222.0	$ 323.6	$ 185.0	(31.4)%	74.9 %

Provision for Doubtful Accounts and Operating Expenses as a % of Net Operating Revenues

	For the Year Ended December 31,		
	2014	2013	2012
Provision for doubtful accounts	1.3 %	1.1 %	1.2 %
Operating expenses:			
Salaries and benefits	48.3 %	47.9 %	48.6 %
Hospital-related expenses:			
Other operating expenses	14.6 %	14.2 %	14.1 %
Occupancy costs	1.7 %	2.1 %	2.2 %
Supplies	4.7 %	4.6 %	4.7 %
General and administrative expenses	5.2 %	5.2 %	5.5 %
Depreciation and amortization	4.5 %	4.2 %	3.8 %
Government, class action, and related settlements	(0.1)%	(1.0)%	(0.2)%
Professional fees—accounting, tax, and legal	0.4 %	0.4 %	0.7 %
Total operating expenses	79.3 %	77.6 %	79.5 %

Additional information regarding our operating results for the years ended December 31, 2014, 2013, and 2012 is as follows:

	For the Year Ended December 31,			Percentage Change	
	2014	2013	2012	2014 v. 2013	2013 v. 2012
	(In Millions)				
Net patient revenue - inpatient	$ 2,272.5	$ 2,130.8	$ 2,012.6	6.7 %	5.9 %
Net patient revenue - outpatient & other	133.4	142.4	149.3	(6.3)%	(4.6)%
Net operating revenues	$ 2,405.9	$ 2,273.2	$ 2,161.9	5.8 %	5.1 %
	(Actual Amounts)				
Discharges	134,515	129,988	123,854	3.5 %	5.0 %
Net patient revenue per discharge	$ 16,894	$ 16,392	$ 16,250	3.1 %	0.9 %
Outpatient visits	739,227	806,631	880,182	(8.4)%	(8.4)%
Average length of stay (days)	13.2	13.3	13.4	(0.8)%	(0.7)%
Occupancy %	68.4%	69.3%	68.2%	(1.3)%	1.6 %
# of licensed beds	7,095	6,825	6,656	4.0 %	2.5 %
Full-time equivalents*	16,628	16,172	15,518	2.8 %	4.2 %
Employees per occupied bed	3.44	3.44	3.43	— %	0.3 %

* Excludes approximately 400 full-time equivalents in each year who are considered part of corporate overhead with their salaries and benefits included in *General and administrative expenses* in our consolidated statements of operations. Full-time equivalents included in the above table represent HealthSouth employees who participate in or support the operations of our hospitals and exclude an estimate of full-time equivalents related to contract labor.

We actively manage the productive portion of our *Salaries and benefits* utilizing certain metrics, including employees per occupied bed, or "EPOB." This metric is determined by dividing the number of full-time equivalents, including an estimate of full-time equivalents from the utilization of contract labor, by the number of occupied beds during each period. The number of occupied beds is determined by multiplying the number of licensed beds by our occupancy percentage.

In the discussion that follows, we use "same-store" comparisons to explain the changes in certain performance metrics and line items within our financial statements. We calculate same-store comparisons based on hospitals open throughout both the full current period and prior periods presented. These comparisons include the financial results of market consolidation transactions in existing markets, as it is difficult to determine, with precision, the incremental impact of these transactions on our results of operations.

2014 Compared to 2013

Net Operating Revenues

Net patient revenue from our hospitals was 6.7% higher in 2014 than in 2013. This increase was attributable to a 3.5% increase in patient discharges and a 3.1% increase in net patient revenue per discharge. Discharge growth included a 1.3% increase in same-store discharges. Same-store discharges were negatively impacted by winter storms in the first quarter of 2014 (40 basis points) and the closure of 40 skilled nursing facility beds in June 2014 (20 basis points). Discharge growth from new stores primarily resulted from the consolidation of Fairlawn effective June 1, 2014, as discussed in Note 2, *Business Combinations*, to the accompanying consolidated financial statements. Net patient revenue per discharge in 2014 benefited from Medicare and managed care price adjustments and higher average acuity for the patients served. Net patient revenue per discharge was negatively impacted in the first quarter of 2014 by approximately $9 million for sequestration, which anniversaried on April 1, 2014. Net patient revenue per discharge in 2013 was negatively impacted by contractual allowances established in the fourth quarter of 2013 related to RAC audits (see the "2013 Compared to 2012 — Net Operating Revenues" section of this Item).

Decreased outpatient volumes in 2014 compared to 2013 resulted from the closure of outpatient clinics and continued competition from physicians offering physical therapy services within their own offices.

Provision for Doubtful Accounts

For several years, under programs designated as "widespread probes," certain of our MACs have conducted pre-payment claim reviews of our billings and denied payment for certain diagnosis codes based on medical necessity. We dispute, or "appeal," most of these denials, but the resolution of these disputes can take in excess of two years, and we cannot provide assurance as to our ongoing and future success of these disputes. As such, we make provisions against these receivables in accordance with our accounting policy that necessarily considers historical collection trends of the receivables in this review process as part of our *Provision for doubtful accounts*. Therefore, as we experience increases or decreases in these denials, or if our actual collections of these denials differ from our estimated collections, we may experience volatility in our *Provision for doubtful accounts*. See also Item 1, *Business*, "Sources of Revenues—Medicare Reimbursement," to this report.

The change in our *Provision for doubtful accounts* as a percent of *Net operating revenues* in 2014 compared to 2013 was primarily the result of these continued pre-payment reviews by MACs and substantial delays in the adjudication process at the administrative law judge hearing level. As these denials slowly work their way through the appeal process, we examine our success rate and adjust our historical collection percentage to estimate our *Provision for doubtful accounts*. In the fourth quarter of 2014, we revised our recovery estimates on pending MAC pre-payment claims from 58% to 63% using our historical collection percentage for all amounts denied. For claims we choose to take through all levels of appeal, up to and including administrative law judge hearings, we have historically experienced an approximate 72% success rate.

Salaries and Benefits

Salaries and benefits are the most significant cost to us and represent an investment in our most important asset: our employees. *Salaries and benefits* include all amounts paid to full- and part-time employees who directly participate in or support the operations of our hospitals, including all related costs of benefits provided to employees. It also includes amounts paid for contract labor.

Salaries and benefits increased in 2014 compared to 2013 primarily due to increased patient volumes, including an increase in the number of full-time equivalents as a result of our 2013 and 2014 development activities, and a 2.2% merit increase given to all eligible nonmanagement employees effective October 1, 2013.

The net impact of reductions in self-insurance reserves, the negative impact of sequestration, and start-up costs associated with our de novo hospitals that opened in the fourth quarter of 2014 increased *Salaries and benefits* as a percent of *Net operating revenues* in 2014 compared to 2013. Excluding the impact of these three items, *Salaries and benefits* as a percent of *Net operating revenues* would have been approximately 40 basis points lower in 2014 than in 2013. Group medical and workers' compensation reserves were reduced by approximately $8 million in 2014 as compared to approximately $15 million in 2013.

We provided a 2.25% merit increase to our nonmanagement employees effective October 1, 2014.

Hospital-related Expenses

Other Operating Expenses

Other operating expenses include costs associated with managing and maintaining our hospitals. These expenses include such items as contract services, utilities, non-income related taxes, insurance, professional fees, and repairs and maintenance.

Other operating expenses increased during 2014 compared to 2013 primarily as a result of increased patient volumes and approximately $7 million of lower reductions to self-insurance reserves for general and professional liability in 2014 than in 2013. As a percent of *Net operating revenues*, *Other operating expenses* for 2014 increased when compared to 2013 due primarily to these same lower reductions to self-insurance reserves. The increase in *Other operating expenses* as a percent of *Net operating revenues* for 2014 compared to 2013 also included the effects of sequestration experienced in the first quarter of 2014.

Occupancy costs

Occupancy costs include amounts paid for rent associated with leased hospitals and outpatient rehabilitation satellite clinics, including common area maintenance and similar charges. *Occupancy costs* decreased in total and as a percent of *Net operating revenues* in 2014 compared to 2013 due to our purchases of the real estate previously subject to operating leases at certain of our hospitals in the latter half of 2013 and first quarter of 2014.

Supplies

Supplies expense includes all costs associated with supplies used while providing patient care. Specifically, these costs include pharmaceuticals, food, needles, bandages, and other similar items. *Supplies* expense as a percent of *Net operating revenues* increased by 10 basis points during the 2014 compared to 2013 due primarily to the impact of sequestration on our *Net operating revenues* in the first quarter of 2014.

General and Administrative Expenses

General and administrative expenses primarily include administrative expenses such as information technology services, human resources, corporate accounting, legal services, and internal audit and controls that are managed from our corporate headquarters in Birmingham, Alabama. These expenses also include stock-based compensation expenses.

In March 2008, we sold our corporate campus to Daniel Corporation ("Daniel"), a Birmingham, Alabama-based real estate company. The sale included a deferred purchase price component related to an incomplete 13-story building located on the property, often referred to as the Digital Hospital. Under the agreement, Daniel was obligated upon sale of its interest in the building to pay to us 40% of the net profit realized from the sale. In June 2013, Daniel sold the building to Trinity Medical Center. In the third quarter of 2013, we received $10.8 million in cash from Daniel in connection with the sale of the building. The gain associated with this transaction is being deferred and amortized over five years, which was the remaining life of our lease agreement with Daniel for the portion of the property we continue to occupy with our corporate office at the time of the transaction, as a component of *General and administrative expenses*. Approximately $2 million and $1 million of this gain was included in *General and administrative expenses* in 2014 and 2013, respectively.

General and administrative expenses in 2014 included $9.3 million of transaction expenses related to our acquisition of Encompass. These one-time expenses were offset by decreased expenses associated with stock-based compensation and our Senior Management Bonus Program discussed in Note 14, *Employee Benefit Plans*, to the accompanying consolidated financial statements, as well as the amortization of the deferred gain on the Digital Hospital discussed above. *General and administrative expenses* were flat as a percent of *Net operating revenues* in 2014 compared to 2013 due primarily to our increasing revenue.

Depreciation and Amortization

Depreciation and amortization increased during 2014 compared to 2013 due to our increased capital expenditures and development activities throughout 2013 and 2014. We expect *Depreciation and amortization* to increase going forward as a result of our recent and ongoing capital investments.

Government, Class Action, and Related Settlements

The gain included in *Government, class action, and related settlements* in 2013 resulted from a noncash reduction in the estimated liability associated with the apportionment obligation to the plaintiffs in the January 2007 comprehensive

settlement of the consolidated securities action, the collection of final judgments against former officers, and the recovery of assets from former officers, as discussed in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Professional Fees — Accounting, Tax, and Legal

Professional fees—accounting, tax, and legal for 2014 and 2013 related primarily to legal and consulting fees for continued litigation and support matters discussed in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Loss on Early Extinguishment of Debt

The *Loss on early extinguishment of debt* in 2014 resulted from the redemption of our 7.25% Senior Notes due 2018 and the redemption of 10% of the outstanding principal amount of our 7.75% Senior Notes due 2022 in the fourth quarter of 2014. The *Loss on early extinguishment of debt* in 2013 resulted from the redemption of 10% of the outstanding principal amount of our 7.25% Senior Notes due 2018 and our 7.75% Senior Notes due 2022 in November 2013.

In January 2015, we issued an additional $400 million of our 5.75% Senior Notes due 2024 at a price of 102% of the principal amount and used $250 million of the net proceeds to repay borrowings under our term loan facilities, with the remaining net proceeds used to repay borrowings under our revolving credit facility. As a result of this transaction, we expect to record an approximate $2 million *Loss on early extinguishment of debt* in the first quarter of 2015.

See Note 8, *Long-term Debt*, to the accompanying consolidated financial statements.

Interest Expense and Amortization of Debt Discounts and Fees

The increase in *Interest expense and amortization of debt discounts and fees* during 2014 compared to 2013 primarily resulted from the noncash amortization of debt discounts and financing costs associated with the issuance of our 2.00% Convertible Senior Subordinated Notes due 2043 in November 2013. While our average borrowings increased in 2014 primarily as a result of issuing the convertible notes, our average cash interest rate decreased from 7.1% in 2013 to 6.2% in 2014. Cash paid for interest approximated $101 million and $99 million in 2014 and 2013, respectively.

Average borrowings outstanding are expected to increase in 2015 primarily as a result of the acquisition of Encompass. In turn, interest expense is also expected to increase. See Note 8, *Long-term Debt*, to the accompanying consolidated financial statements.

Other Income

Other income for 2014 included a $27.2 million gain related to the acquisition of an additional 30% equity interest in Fairlawn. See Note 2, *Business Combinations*, to the accompanying consolidated financial statements.

Income from Continuing Operations Before Income Tax Expense

Our pre-tax income from continuing operations for 2014 reflected continued revenue growth and increases in interest expense and depreciation and amortization. Pre-tax income was also impacted by three items having a net, favorable impact of $4.7 million. These items included the $27.2 million gain on the consolidation of Fairlawn offset by the $13.2 million *Loss on early extinguishment of debt* and $9.3 million of Encompass transaction expenses. Pre-tax income from continuing operations for 2013 included $23.5 million of gains related to *Government, class action, and related settlements*.

Provision for Income Tax Expense

Due to our federal and state net operating losses ("NOLs"), our cash income taxes approximated $16 million, net of refunds, in 2014. These payments resulted primarily from state income tax expense of subsidiaries which have separate state filing requirements, alternative minimum taxes, and federal income taxes for subsidiaries not included in our federal consolidated income tax return. In 2015, we estimate we will pay approximately $15 million to $20 million of cash income taxes, net of refunds. In 2014 and 2013, current income tax expense was $13.3 million and $6.3 million, respectively.

Our effective income tax rate for 2014 was 28.6%. Our *Provision for income tax expense* in 2014 was less than the federal statutory rate of 35% primarily due to: (1) the impact of noncontrolling interests, (2) the nontaxable gain discussed in Note 2, *Business Combinations*, related to our acquisition of an additional 30% equity interest in Fairlawn, and (3) a decrease in our valuation allowance offset by (4) state and other income tax expense. See Note 1, *Summary of Significant Accounting*

Policies, "Income Taxes," for a discussion of the allocation of income or loss related to pass-through entities, which is referred to as the impact of noncontrolling interests in this discussion. As a result of the Fairlawn transaction, we released the deferred tax liability associated with the outside tax basis of our investment in Fairlawn because we now possess sufficient ownership to allow for the historical outside tax basis difference to be resolved through a tax-free transaction in the future. The decrease in our valuation allowance in 2014 related primarily to the expiration of state NOLs in certain jurisdictions, our current forecast of future earnings in each jurisdiction, and changes in certain state tax laws.

In April 2013, we entered into closing agreements with the IRS that settled federal income tax matters related to the previous restatement of our 2000 and 2001 financial statements, as well as certain other tax matters, through December 31, 2008. As a result of these closing agreements, we increased our deferred tax assets, primarily our federal NOL, and recorded a net income tax benefit of approximately $115 million in the second quarter of 2013. This federal income tax benefit primarily resulted from an approximate $283 million increase to our federal NOL on a gross basis.

Our effective income tax rate for 2013 was 3.2%. Our *Provision for income tax expense* in 2013 was less than the federal statutory rate of 35.0% primarily due to: (1) the IRS settlement discussed above, (2) the impact of noncontrolling interests, and (3) a decrease in our valuation allowance offset by (4) state and other income tax expense. The decrease in our valuation allowance in 2013 related primarily to our capital loss carryforwards, our then current forecast of future earnings in each jurisdiction, and changes in certain state tax laws. During the second quarter of 2013, we determined a valuation allowance related to our capital loss carryforwards was no longer required as sufficient positive evidence existed to substantiate their utilization. This evidence included our partial utilization of these assets as a result of realizing capital gains in 2013 and the identification of sufficient taxable capital gain income within the available capital loss carryforward period.

In certain state jurisdictions, we do not expect to generate sufficient income to use all of the available NOLs prior to their expiration. This determination is based on our evaluation of all available evidence in these jurisdictions including results of operations during the preceding three years, our forecast of future earnings, and prudent tax planning strategies. It is possible we may be required to increase or decrease our valuation allowance at some future time if our forecast of future earnings varies from actual results on a consolidated basis or in the applicable state tax jurisdiction, or if the timing of future tax deductions differs from our expectations.

We recognize the financial statement effects of uncertain tax positions when it is more likely than not, based on the technical merits, a position will be sustained upon examination by and resolution with the taxing authorities. Total remaining gross unrecognized tax benefits were $0.9 million and $1.1 million as of December 31, 2014 and 2013, respectively.

See Note 16, *Income Taxes*, to the accompanying consolidated financial statements and the "Critical Accounting Estimates" section of this Item.

Net Income Attributable to Noncontrolling Interests

Net income attributable to noncontrolling interests represents the share of net income or loss allocated to members or partners in our consolidated affiliates. Fluctuations in these amounts are primarily driven by the financial performance of the applicable hospital population each period.

2013 Compared to 2012

Net Operating Revenues

Net patient revenue from our hospitals was 5.9% higher for the year ended December 31, 2013 than the year ended December 31, 2012. This increase was attributable to a 5.0% increase in patient discharges and a 0.9% increase in net patient revenue per discharge. Discharge growth included a 2.5% increase in same-store discharges. Same-store discharges were negatively impacted by the divestiture of 41 skilled nursing facility beds in the first quarter of 2013. Approximately 60 basis points of discharge growth from new stores resulted from the consolidation of St. Vincent Rehabilitation Hospital beginning in the third quarter of 2012, as discussed in Note 7, *Investments in and Advances to Nonconsolidated Affiliates*, to the accompanying consolidated financial statements. The increase in net patient revenue per discharge resulted from pricing adjustments, higher patient acuity, and a higher percentage of Medicare patients. Net patient revenue per discharge was negatively impacted in 2013 by sequestration (became effective for all discharges after April 1, 2013), the impact of post-payment claim reviews (as discussed below), and the ramping up of three new hospitals. New hospitals are required to treat a minimum of 30 patients for zero revenue as part of the Medicare certification process.

As discussed in Item 1, *Business*, and the "Critical Accounting Estimates—Revenue Recognition" section of this Item, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to

conduct claims and medical record audits. In connection with CMS approved and announced RAC audits related to IRFs, we received requests in 2013 to review certain patient files for discharges occurring from 2010 to 2013. While we make provisions for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs, we cannot provide assurance as to our future success in the resolution of these and future disputes, nor can we predict or estimate the scope or number of denials that ultimately may be received. During 2013, we reduced our *Net operating revenues* by approximately $8 million for post-payment claims that are part of this review process.

Decreased outpatient volumes in 2013 compared to 2012 resulted from the closure of outpatient clinics and continued competition from physicians offering physical therapy services within their own offices. Outpatient and other revenues for 2013 included approximately $6 million more in state provider tax refunds than 2012.

Provision for Doubtful Accounts

The change in our *Provision for doubtful accounts* as a percent of *Net operating revenues* in 2013 compared to 2012 was primarily the result of a decrease in pre-payment claims denials by MACs.

Salaries and Benefits

Salaries and benefits increased in 2013 compared to 2012 primarily due to increased patient volumes, including an increase in the number of full-time equivalents as a result of our 2012 and 2013 development activities, and increased costs associated with medical plan benefits. Because merit increases were foregone in 2012, as discussed below, management determined the Company would absorb all of the increased costs associated with medical plan benefits to employees in 2013. These cost increases were offset by adjustments to our workers' compensation accruals in 2013 due to favorable trends in claims and industry-wide loss development trends. As a result of these continued favorable trends, we also lowered the statistical confidence level used to determine our self-insurance reserves in 2013. See Note 9, *Self-Insured Risks*, to the accompanying consolidated financial statements.

Salaries and benefits as a percent of *Net operating revenues* decreased in 2013 compared to 2012 due to our increasing revenue, the favorable adjustments to our workers' compensation accruals discussed above, and the one-time, merit-based, year-end bonus paid in the fourth quarter of 2012 to all eligible nonmanagement employees in lieu of an annual merit increase. The fourth quarter of 2013 included a 2.2% merit increase whereas the fourth quarter of 2012 included an approximate $10 million bonus in lieu of a merit increase resulting in a year-over-year benefit of approximately $5.5 million in *Salaries and benefits* in 2013. The positive impact of all of the above items were offset by sequestration.

Hospital-related Expenses

Other Operating Expenses

Other operating expenses increased during 2013 compared to 2012 primarily as a result of increased patient volumes, including new hospitals, and the ongoing implementation of our clinical information system. *Other operating expenses* associated with the ongoing implementation of our clinical information system were approximately $3 million higher in 2013 than in 2012.

As a percent of *Net operating revenues*, *Other operating expenses* increased during 2013 compared to 2012 due to the effects of sequestration, the ramping up of operations at three new hospitals, and higher expenses associated with the ongoing implementation of our clinical information system offset by growth in our revenue and a reduction in general and professional liability reserves due to favorable trends in claims and industry-wide loss development trends. As a result of these continued favorable trends, we also lowered the statistical confidence level used to determine our self-insurance reserves in 2013. See Note 9, *Self-Insured Risks*, to the accompanying consolidated financial statements.

Occupancy costs

Occupancy costs decreased as a percent of *Net operating revenues* in 2013 compared to 2012 due to our purchases of the real estate previously subject to operating leases at certain of our hospitals in 2013 and 2012.

Supplies

Supplies expense decreased as a percent of *Net operating revenues* in 2013 compared to 2012 due to our supply chain efforts and continual focus on monitoring and actively managing pharmaceutical costs offset by sequestration.

General and Administrative Expenses

General and administrative expenses decreased as a percent of *Net operating revenues* in 2013 compared to 2012 due primarily to our increasing revenue.

Depreciation and Amortization

Depreciation and amortization increased during 2013 compared to 2012 due to our increased capital expenditures throughout 2012 and 2013.

Government, Class Action, and Related Settlements

As discussed above, the gain included in *Government, class action, and related settlements* in 2013 resulted from a noncash reduction in the estimated liability associated with the apportionment obligation to the plaintiffs in the January 2007 comprehensive settlement of the consolidated securities action, the collection of final judgments against former officers, and the recovery of assets from former officers. The gain included in *Government, class action, and related settlements* in 2012 resulted from the recovery of assets from former officers. See Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements.

Professional Fees — Accounting, Tax, and Legal

Professional fees—accounting, tax, and legal for 2013 and 2012 related primarily to legal and consulting fees for continued litigation and support matters discussed in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements. These expenses in 2012 also included legal and consulting fees for the pursuit of our remaining income tax benefits as discussed in Note 16, *Income Taxes*, to the accompanying consolidated financial statements.

Loss on Early Extinguishment of Debt

As discussed above, the *Loss on early extinguishment of debt* in 2013 resulted from the redemption of 10% of the outstanding principal amount of our 7.25% Senior Notes due 2018 and our 7.75% Senior Notes due 2022 in November 2013. The *Loss on early extinguishment of debt* in 2012 resulted from the amendment to our credit agreement in August 2012 and the redemption of 10% of the outstanding principal amount of our 7.25% Senior Notes due 2018 and our 7.75% Senior Notes due 2022 in October 2012. See Note 8, *Long-term Debt*, to the accompanying consolidated financial statements.

Interest Expense and Amortization of Debt Discounts and Fees

The increase in *Interest expense and amortization of debt discounts and fees* during 2013 compared to 2012 resulted from an increase in our average borrowings outstanding offset by a decrease in our average cash interest rate. Average borrowings outstanding increased during 2013 compared to 2012 primarily as a result of our issuance of $275 million aggregate principal amount of 5.75% Senior Notes due 2024 in September 2012. Our average cash interest rate approximated 7.1% and 7.2% during 2013 and 2012, respectively. The decrease in our average cash interest rate primarily resulted from the August 2012 amendment to our credit agreement that lowered the interest rate spread on our revolving credit facility by 50 basis points. See Note 8, *Long-term Debt*, to the accompanying consolidated financial statements.

Other Income

Other income is primarily comprised of interest income and gains and losses on sales of investments. In 2012, *Other income* included a $4.9 million gain as a result of our consolidation of St. Vincent Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value. See Note 7, *Investments in and Advances to Nonconsolidated Affiliates*, to the accompanying consolidated financial statements.

Income from Continuing Operations Before Income Tax Expense

The increase in our pre-tax income from continuing operations in 2013 compared to 2012 resulted from increased *Net operating revenues* and continued disciplined expense management. Pre-tax income in 2013 and 2012 included gains of $23.5 million and $3.5 million, respectively, related to *Government, class action, and related settlements*, as discussed above. Pre-tax income for 2012 also included a $4.9 million gain on the consolidation of St. Vincent Rehabilitation Hospital, as discussed above.

Provision for Income Tax Expense

As discussed above, our effective income tax rate for 2013 was 3.2%, which was less than the federal statutory rate of 35.0% primarily due to: (1) the IRS settlement discussed above, (2) the impact of noncontrolling interests, and (3) a decrease in our valuation allowance offset by (4) state and other income tax expense.

Our effective income tax rate for 2012 was 31.9%. Our *Provision for income tax expense* in 2012 was less than the federal statutory rate of 35.0% primarily due to: (1) the impact of noncontrolling interests and (2) a decrease in the valuation allowance offset by (3) state and other income tax expense.

Total remaining gross unrecognized tax benefits were $1.1 million and $78.0 million as of December 31, 2013 and 2012, respectively. The amount of gross unrecognized tax benefits changed during 2013 primarily due to the settlement with the IRS discussed above.

See Note 16, *Income Taxes*, to the accompanying consolidated financial statements and the "Critical Accounting Estimates" section of this Item.

Net Income Attributable to Noncontrolling Interests

Net income attributable to noncontrolling interests represents the share of net income or loss allocated to members or partners in our consolidated affiliates. Fluctuations in these amounts are primarily driven by the financial performance of the applicable hospital population each period. Approximately $4 million of the increase in noncontrolling interests in 2013 compared to 2012 was due to changes at two of our existing hospitals. During 2013, we entered into an agreement to convert our 100% owned hospital in Jonesboro, Arkansas into a joint venture with St. Bernards Healthcare. In addition, our share of profits from our joint venture hospital in Memphis, Tennessee decreased in 2013 from 70% to 50% pursuant to the terms of that partnership agreement entered into in 1993.

Impact of Inflation

The impact of inflation on the Company will be primarily in the area of labor costs. The healthcare industry is labor intensive. Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. While we believe the current economic climate may help to moderate wage increases in the near term, there can be no guarantee we will not experience increases in the cost of labor, as the need for clinical healthcare professionals is expected to grow. In addition, increases in healthcare costs are typically higher than inflation and impact our costs under our employee benefit plans. Managing these costs remains a significant challenge and priority for us.

Suppliers pass along rising costs to us in the form of higher prices. Our supply chain efforts and our continual focus on monitoring and actively managing pharmaceutical costs has enabled to us to accommodate increased pricing related to supplies and other operating expenses over the past few years. However, we cannot predict our ability to cover future cost increases.

It should be noted that we have little or no ability to pass on these increased costs associated with providing services to Medicare and Medicaid patients due to federal and state laws that establish fixed reimbursement rates.

Relationships and Transactions with Related Parties

Related party transactions were not material to our operations in 2014, 2013, or 2012, and therefore, are not presented as a separate discussion within this Item.

Encompass internally developed, and is now a licensee of, Homecare Homebase℠, a comprehensive information platform that allows home health providers to process clinical, compliance, and marketing information as well as analyze data and trends for management purposes using custom reports. This software is licensed to Encompass by Homecare Homebase, LP. April Anthony, Chief Executive Officer of Encompass, is an investor and an officer of Homecare Homebase. Going forward, we expect to pay Homecare Homebase for software licenses and maintenance.

Results of Discontinued Operations

In connection with the 2007 sale of our surgery centers division (now known as Surgical Care Affiliates, or "SCA") to ASC Acquisition LLC, an affiliate of TPG Partners V, L.P. ("TPG"), a private investment partnership, we received an option, subject to terms and conditions set forth below, to purchase up to a 5% equity interest in SCA. The price of the option is equal to the original issuance price of the units subscribed for by TPG and certain other co-investors in connection with the acquisition plus a 15% premium, compounded annually. The option has a term of ten years and is exercisable upon certain

liquidity events, including a public offering of SCA's shares of common stock that results in 30% or more of SCA's common stock being listed or traded on a national securities exchange. On November 4, 2013, SCA announced the closing of its initial public offering, which was not a qualifying liquidity event.

During the second quarter of 2014, we entered into an amendment to the option agreement that requires us to settle the option net of our exercise price. The addition of this new feature resulted in the option becoming a derivative that must be recorded as an asset or liability on our consolidated balance sheet and marked to market each period. As of December 31, 2014, the fair value of this option was $9.9 million and is included in *Other long-term assets* in our consolidated balance sheet. *Income from discontinued operations, net of tax* for 2014 included a $9.9 million net gain resulting from the initial recording of this option as a derivative and its fair value adjustments during 2014. If the option becomes exercisable, we believe it will have a strike price below the price of the asset being purchased.

Income from discontinued operations, net of tax, in 2012 primarily resulted from gains associated with the sale of the real estate of Dallas Medical Center and an investment we had in a cancer treatment center that was part of our former diagnostic division.

For additional information regarding discontinued operations, see Note 15, *Assets and Liabilities in and Results of Discontinued Operations*, to the accompanying consolidated financial statements.

Liquidity and Capital Resources

Our primary sources of liquidity are cash on hand, cash flows from operations, and borrowings under our revolving credit facility.

The objectives of our capital structure strategy are to ensure we maintain adequate liquidity and flexibility. Pursuing and achieving those objectives allows us to support the execution of our operating and strategic plans and weather temporary disruptions in the capital markets and general business environment. Maintaining adequate liquidity is a function of our unrestricted *Cash and cash equivalents* and our available borrowing capacity. Maintaining flexibility in our capital structure is a function of, among other things, the amount of debt maturities in any given year, the options for debt prepayments without onerous penalties, and limiting restrictive terms and maintenance covenants in our debt agreements.

Consistent with these objectives, in September 2014, we issued an additional $175 million of our 5.75% Senior Notes due 2024 at a price of 103.625% of the principal amount. In September and December 2014, we amended our existing credit agreement to, among other things:

- add $450 million of term loan capacity to our existing $600 million revolving credit facility;
- permit unlimited restricted payments so long as the senior secured leverage ratio remains less than or equal to 1.75x (previously 1.50x);
- increase the amount of permitted capital expenditures in a given year from $250 million to $300 million; and
- set the maturity date for both the revolving credit and term loan facilities to September 2019, which represented a 15-month extension for our existing revolving credit facility.

In October 2014, we used the net proceeds from the September offering of senior notes, a $75 million draw under our term loan facility, and cash on hand to redeem the outstanding principal amount of our 7.25% Senior Notes due 2018. Pursuant to the terms of the 7.25% Senior Notes due 2018, this redemption was made at a price of 103.625%, which resulted in a total cash outlay of approximately $281 million to retire the approximately $271 million in principal. Additionally, in December 2014, we redeemed approximately $25 million of the outstanding principal amount of our existing 7.75% Senior Notes due 2022. Pursuant to the terms of these senior notes, this optional redemption represented 10% of the outstanding principal amount of the notes at a price of 103%, which resulted in a total cash outlay of approximately $26 million. As a result of these redemptions, we recorded an approximate $13 million *Loss on early extinguishment of debt* in the fourth quarter of 2014.

In December 2014, we drew $375 million under our expanded term loan facilities and $325 million under our revolving credit facility to fund the acquisition of Encompass. In January 2015, we issued an additional $400 million of our 5.75% Senior Notes due 2024 at a price of 102% of the principal amount and used $250 million of the net proceeds to repay borrowings under our term loan facilities, with the remaining net proceeds used to repay borrowings under our revolving credit facility. As a result of this transaction, we expect to record an approximate $2 million *Loss on early extinguishment of debt* in the first quarter of 2015.

We have been disciplined in creating a capital structure that is flexible with no significant debt maturities prior to 2019. Our balance sheet remains strong, and we have significant availability under our credit agreement. We continue to generate strong cash flows from operations, and we have significant flexibility with how we choose to invest our cash and return capital to shareholders.

See Note 8, *Long-term Debt*, to the accompanying consolidated financial statements.

Current Liquidity

As of December 31, 2014, we had $66.7 million in *Cash and cash equivalents*. This amount excludes $45.6 million in *Restricted cash* and $50.5 million of restricted marketable securities ($45.9 million of restricted marketable securities are included in *Other long-term assets* in our consolidated balance sheet). Our restricted assets pertain primarily to obligations associated with our captive insurance company, as well as obligations we have under agreements with joint venture partners. See Note 3, *Cash and Marketable Securities*, to the accompanying consolidated financial statements.

In addition to *Cash and cash equivalents*, as of December 31, 2014, we had approximately $243 million available to us under our revolving credit facility. Our credit agreement governs the substantial majority of our senior secured borrowing capacity and contains a leverage ratio and an interest coverage ratio as financial covenants. Our leverage ratio is defined in our credit agreement as the ratio of consolidated total debt (less up to $75 million of cash on hand) to Adjusted EBITDA for the trailing four quarters. Our interest coverage ratio is defined in our credit agreement as the ratio of Adjusted EBITDA to consolidated interest expense, excluding the amortization of financing fees, for the trailing four quarters. As of December 31, 2014, the maximum leverage ratio requirement per our credit agreement was 4.25x and the minimum interest coverage ratio requirement was 2.75x, and we were in compliance with these covenants. Based on Adjusted EBITDA for 2014 and the interest rate in effect under our credit agreement during the three-month period ended December 31, 2014, if we had drawn on the first day and maintained the maximum amount of outstanding draws under our revolving credit facility for the entire year, we would still be in compliance with the maximum leverage ratio and minimum interest coverage ratio requirements.

We do not face near-term refinancing risk, as the amounts outstanding under our credit agreement do not mature until 2019, and our bonds all mature in 2020 and beyond. See the "Contractual Obligations" section below for information related to our contractual obligations as of December 31, 2014.

We anticipate we will continue to generate strong cash flows from operations that, together with availability under our revolving credit facility, will allow us to invest in growth opportunities and continue to improve our existing business. We also will continue to consider additional shareholder value-enhancing strategies such as repurchases of our common and preferred stock and common stock dividends, including the potential growth of the quarterly cash dividend on our common stock, recognizing that these actions may increase our leverage ratio. See also the "Authorizations for Returning Capital to Stakeholders" section of this Item.

See Item 1A, *Risk Factors*, for a discussion of risks and uncertainties facing us.

Sources and Uses of Cash

The following table shows the cash flows provided by or used in operating, investing, and financing activities for the years ended December 31, 2014, 2013, and 2012 (in millions):

	For the Year Ended December 31,		
	2014	2013	2012
Net cash provided by operating activities	$ 444.9	$ 470.8	$ 411.5
Net cash used in investing activities	(876.9)	(226.2)	(178.8)
Net cash provided by (used in) financing activities	434.2	(312.4)	(130.0)
Increase (decrease) in cash and cash equivalents	$ 2.2	$ (68.3)	$ 102.7

2014 Compared to 2013

Operating activities. The decrease in *Net cash provided by operating activities* from 2013 to 2014 primarily resulted from growth in accounts receivable due to additional claims denials predominantly by one Medicare Administrative Contractor and continued delays at the administrative law judge hearing level. See Item 1, *Business*, "Sources of Revenues—Medicare Reimbursement—Inpatient Rehabilitation."

Investing activities. The increase in *Net cash used in investing activities* during 2014 compared to 2013 primarily resulted from the acquisition of Encompass. The total cash consideration delivered at closing was $695.5 million.

Financing activities. Net cash provided by financing activities in 2014 primarily resulted from draws under the revolving and expanded term loan facilities of our credit agreement to fund the acquisition of Encompass. Excluding the Encompass-related borrowings, *Net cash used in financing activities* would have decreased in 2014 primarily due to repurchases of our common stock as part of a tender offer in the first quarter of 2013 offset by an increase in common stock cash dividends in 2014.

See Note 2, *Business Combinations*, Note 8, *Long-term Debt*, and Note 17, *Earnings per Common Share*, to the accompanying consolidated financial statements.

2013 Compared to 2012

Operating activities. Net cash provided by operating activities increased from 2012 to 2013 due primarily to increased *Net operating revenues* and continued disciplined expense management.

Investing activities. The increase in *Net cash used in investing activities* during 2013 compared to 2012 primarily resulted from increased capital expenditures and the acquisition of Walton Rehabilitation Hospital. The increase in our capital expenditures in 2013 primarily resulted from the purchase of the real estate previously subject to leases associated with four of our hospitals. *Net cash used in investing activities* during 2013 also included the receipt of $10.8 million related to the sale of the Digital Hospital. See Note 2, *Business Combinations*, and Note 5, *Property and Equipment*, to the accompanying consolidated financial statements.

Financing activities. The increase in *Net cash used in financing activities* during 2013 compared to 2012 primarily resulted from repurchases of our common stock as part of the tender offer completed in the first quarter of 2013. As discussed in Note 17, *Earnings per Common Share*, to the accompanying consolidated financial statements, we repurchased approximately 9.1 million shares of our common stock for $234.1 million, including fees and expenses related to the tender offer.

Contractual Obligations

Our consolidated contractual obligations as of December 31, 2014 are as follows (in millions):

	Total	2015	2016-2017	2018-2019	2020 and thereafter
Long-term debt obligations:					
Long-term debt, excluding revolving credit facility and capital lease obligations [a][b]	$ 1,719.9	$ 12.6	$ 23.4	$ 177.5	$ 1,506.4
Revolving credit facility [b]	325.0	—	—	325.0	—
Interest on long-term debt [c]	794.6	93.2	184.5	178.1	338.8
Capital lease obligations [d]	167.0	15.3	29.0	24.3	98.4
Operating lease obligations [e][f]	249.9	43.8	69.4	49.4	87.3
Purchase obligations [f][g]	103.3	32.5	34.3	20.6	15.9
Other long-term liabilities [h][i]	3.8	0.3	0.4	0.4	2.7
Total	$ 3,363.5	$ 197.7	$ 341.0	$ 775.3	$ 2,049.5

(a) Included in long-term debt are amounts owed on our bonds payable and other notes payable. These borrowings are further explained in Note 8, *Long-term Debt,* to the accompanying consolidated financial statements.

(b) In January 2015, we issued an additional $400 million of our 5.75% Senior Notes due 2024 at a price of 102% of the principal amount. We used $250 million of the net proceeds from this additional offering of senior notes to repay borrowings under our term loan facilities. The remaining net proceeds were used to repay borrowings under our revolving credit facility. See Note 8, *Long-term Debt*, to the accompanying consolidated financial statements.

(c) Interest on our fixed rate debt is presented using the stated interest rate. Interest expense on our variable rate debt is estimated using the rate in effect as of December 31, 2014. Interest related to capital lease obligations is excluded from this line. Future minimum payments, which are accounted for as interest, related to sale/leaseback transactions

involving real estate accounted for as financings are included in this line (see Note 5, *Property and Equipment*, and Note 8, *Long-term Debt*, to the accompanying consolidated financial statements). Amounts exclude amortization of debt discounts, amortization of loan fees, or fees for lines of credit that would be included in interest expense in our consolidated statements of operations.

(d) Amounts include interest portion of future minimum capital lease payments.

(e) We lease approximately 15% of our hospitals as well as other property and equipment under operating leases in the normal course of business. Some of our hospital leases contain escalation clauses based on changes in the Consumer Price Index while others have fixed escalation terms. The minimum lease payments do not include contingent rental expense. Some lease agreements provide us with the option to renew the lease or purchase the leased property. Our future operating lease obligations would change if we exercised these renewal options and if we entered into additional operating lease agreements. For more information, see Note 5, *Property and Equipment,* to the accompanying consolidated financial statements.

(f) Future operating lease obligations and purchase obligations are not recognized in our consolidated balance sheet.

(g) Purchase obligations include agreements to purchase goods or services that are enforceable and legally binding on HealthSouth and that specify all significant terms, including: fixed or minimum quantities to be purchased; fixed, minimum, or variable price provisions; and the approximate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty. Our purchase obligations primarily relate to software licensing and support.

(h) Because their future cash outflows are uncertain, the following noncurrent liabilities are excluded from the table above: general liability, professional liability, and workers' compensation risks, noncurrent amounts related to third-party billing audits, and deferred income taxes. Also, as of December 31, 2014, we had $0.9 million of total gross unrecognized tax benefits. For more information, see Note 9, *Self-Insured Risks,* Note 16, *Income Taxes,* and Note 18, *Contingencies and Other Commitments,* to the accompanying consolidated financial statements.

(i) The table above does not include *Redeemable noncontrolling interests* of $84.7 million because of the uncertainty surrounding the timing and amounts of any related cash outflows. See Note 11, *Redeemable Noncontrolling Interests*, to the accompanying consolidated financial statements.

Our capital expenditures include costs associated with our hospital refresh program, de novo projects, capacity expansions, technology initiatives, and building and equipment upgrades and purchases. During the year ended December 31, 2014, we made capital expenditures of approximately $188 million for property and equipment and capitalized software. These expenditures included approximately $17 million for the purchase of the real estate previously subject to a lease associated with our hospital in San Antonio, Texas and approximately $12 million of hospital and technology equipment that was received in 2013 but not paid for until 2014. These expenditures in 2014 are exclusive of approximately $695 million in net cash related to our acquisition activities in 2014, including the acquisition of Encompass, as discussed in Note 2, *Business Combinations*, to the accompanying consolidated financial statements.

During 2015, we expect to spend approximately $190 million to $240 million for capital expenditures. This estimated range for capital expenditures is exclusive of hospital acquisitions, but it includes an estimated range of $30 million to $40 million for new home health and hospice agencies. Approximately $90 million to $100 million of this budgeted amount is considered nondiscretionary expenditures, which we may refer to in other filings as "maintenance" expenditures. Actual amounts spent will be dependent upon the timing of construction projects and acquisition opportunities for our home health and hospice business.

Authorizations for Returning Capital to Stakeholders

On October 15, 2013, we paid the first cash dividend, $0.18 per share, on our common stock, and we paid the same per share dividend quarterly through July 15, 2014. On July 17, 2014, our board of directors approved an increase in our quarterly dividend to $0.21 per share, which was paid on October 15, 2014 to stockholders of record on October 1, 2014. On October 21, 2014, our board of directors declared a cash dividend of $0.21 per share, payable on January 15, 2015 to stockholders of record on January 2, 2015. We expect quarterly dividends to be paid in January, April, July, and October. However, the actual declaration of any future cash dividends, and the setting of record and payment dates as well as the per share amounts, will be at the discretion of our board of directors after consideration of various factors, including our capital position and alternative uses of funds. Cash dividends are expected to be funded using cash flows from operations, cash on hand, and availability under our credit agreement.

The payment of cash dividends on our common stock triggers antidilution adjustments, except in instances when such adjustments are deemed *de minimis,* under our convertible notes and our convertible perpetual preferred stock. See Note 8, *Long-term Debt*, Note 10, *Convertible Perpetual Preferred Stock*, and Note 17, *Earnings per Common Share*, to the accompanying consolidated financial statements.

On February 14, 2014, our board of directors approved an increase in our existing common stock repurchase authorization from $200 million to $250 million. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. Subject to certain terms and conditions, including a maximum price per share and compliance with federal and state securities and other laws, the repurchases may be made from time to time in open market transactions, privately negotiated transactions, or other transactions, including trades under a plan established in accordance with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. During 2014, we repurchased 1.3 million shares of our common stock in the open market for $43.1 million under this repurchase authorization using cash on hand. Future repurchases under this authorization generally are expected to be funded using a combination of cash on hand and availability under our $600 million revolving credit facility.

Adjusted EBITDA

Management believes Adjusted EBITDA as defined in our credit agreement is a measure of our ability to service our debt and our ability to make capital expenditures. We reconcile Adjusted EBITDA to *Net income* and to *Net cash provided by operating activities*.

We use Adjusted EBITDA on a consolidated basis as a liquidity measure. We believe this financial measure on a consolidated basis is important in analyzing our liquidity because it is the key component of certain material covenants contained within our credit agreement, which is discussed in more detail in Note 8, *Long-term Debt*, to the accompanying consolidated financial statements. These covenants are material terms of the credit agreement. Noncompliance with these financial covenants under our credit agreement — our interest coverage ratio and our leverage ratio — could result in our lenders requiring us to immediately repay all amounts borrowed. If we anticipated a potential covenant violation, we would seek relief from our lenders, which would have some cost to us, and such relief might be on terms less favorable to us than those in our existing credit agreement. In addition, if we cannot satisfy these financial covenants, we would be prohibited under our credit agreement from engaging in certain activities, such as incurring additional indebtedness, paying common stock dividends, making certain payments, and acquiring and disposing of assets. Consequently, Adjusted EBITDA is critical to our assessment of our liquidity.

In general terms, the credit agreement definition of Adjusted EBITDA, therein referred to as "Adjusted Consolidated EBITDA," allows us to add back to consolidated *Net income* interest expense, income taxes, and depreciation and amortization and then add back to consolidated *Net income* (1) all unusual or nonrecurring items reducing consolidated *Net income* (of which only up to $10 million in a year may be cash expenditures), (2) any losses from discontinued operations and closed locations, (3) costs and expenses, including legal fees and expert witness fees, incurred with respect to litigation associated with stockholder derivative litigation, including the matters related to Ernst & Young LLP and Richard Scrushy discussed in Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements, and (4) share-based compensation expense. We also subtract from consolidated *Net income* all unusual or nonrecurring items to the extent increasing consolidated *Net income*.

Under the credit agreement, the Adjusted EBITDA calculation does not include net income attributable to noncontrolling interests and includes (1) gain or loss on disposal of assets, (2) professional fees unrelated to the stockholder derivative litigation, and (3) unusual or nonrecurring cash expenditures in excess of $10 million. These items may not be indicative of our ongoing performance, so the Adjusted EBITDA calculation presented here includes adjustments for them.

Adjusted EBITDA is not a measure of financial performance under generally accepted accounting principles in the United States of America, and the items excluded from Adjusted EBITDA are significant components in understanding and assessing financial performance. Therefore, Adjusted EBITDA should not be considered a substitute for *Net income* or cash flows from operating, investing, or financing activities. Because Adjusted EBITDA is not a measurement determined in accordance with GAAP and is thus susceptible to varying calculations, Adjusted EBITDA, as presented, may not be comparable to other similarly titled measures of other companies. Revenues and expenses are measured in accordance with the policies and procedures described in Note 1, *Summary of Significant Accounting Policies*, to the accompanying consolidated financial statements.

Our Adjusted EBITDA for the years ended December 31, 2014, 2013, and 2012 was as follows (in millions):

Reconciliation of Net Income to Adjusted EBITDA

	For the Year Ended December 31,		
	2014	2013	2012
Net income	$ 281.7	$ 381.4	$ 235.9
(Income) loss from discontinued operations, net of tax, attributable to HealthSouth	(5.5)	1.1	(4.5)
Provision for income tax expense	110.7	12.7	108.6
Interest expense and amortization of debt discounts and fees	109.2	100.4	94.1
Loss on early extinguishment of debt	13.2	2.4	4.0
Professional fees—accounting, tax, and legal	9.3	9.5	16.1
Government, class action, and related settlements	(1.7)	(23.5)	(3.5)
Net noncash loss on disposal or impairment of assets	6.7	5.9	4.4
Depreciation and amortization	107.7	94.7	82.5
Stock-based compensation expense	23.9	24.8	24.1
Net income attributable to noncontrolling interests	(59.7)	(57.8)	(50.9)
Gain on consolidation of former equity method hospital	(27.2)	—	(4.9)
Encompass transaction costs	9.3	—	—
Adjusted EBITDA	$ 577.6	$ 551.6	$ 505.9

Reconciliation of Net Cash Provided by Operating Activities to Adjusted EBITDA

	For the Year Ended December 31,		
	2014	2013	2012
Net cash provided by operating activities	$ 444.9	$ 470.3	$ 411.5
Provision for doubtful accounts	(31.6)	(26.0)	(27.0)
Professional fees—accounting, tax, and legal	9.3	9.5	16.1
Interest expense and amortization of debt discounts and fees	109.2	100.4	94.1
Equity in net income of nonconsolidated affiliates	10.7	11.2	12.7
Net income attributable to noncontrolling interests in continuing operations	(59.7)	(57.8)	(50.9)
Amortization of debt-related items	(12.7)	(5.0)	(3.7)
Distributions from nonconsolidated affiliates	(12.6)	(11.4)	(11.0)
Current portion of income tax expense	13.3	6.3	5.9
Change in assets and liabilities	90.1	48.9	58.1
Net premium paid on bond transactions	4.3	1.7	1.9
Operating cash used in (provided by) discontinued operations	1.2	1.9	(2.0)
Encompass transaction costs	9.3	—	—
Other	1.9	1.6	0.2
Adjusted EBITDA	$ 577.6	$ 551.6	$ 505.9

Growth in Adjusted EBITDA from 2013 to 2014 was due primarily to continued revenue growth, as well as an approximate $6 million contribution to Adjusted EBITDA from the increase in ownership and consolidation of Fairlawn. The comparison to last year was negatively impacted by approximately $14 million attributable to lower reductions in our self-insurance reserves in 2014 than in 2013, as discussed in the "Results of Operations" section of this Item. Adjusted EBITDA in 2014 also included approximately $8 million for the negative impact of sequestration in the first quarter of 2014 and approximately $4 million in higher net start-up costs, year over year, for new hospitals.

Growth in Adjusted EBITDA from 2012 to 2013 was due primarily to revenue growth and disciplined expense management. Adjusted EBITDA for 2013 benefited from $6.7 million of adjustments to self-insurance reserves resulting from our change in assumptions related to our statistical confidence level, as discussed in Note 9, *Self-Insured Risks*, to the accompanying consolidated financial statements. Sequestration negatively impacted Adjusted EBITDA by approximately $25 million during 2013.

Off-Balance Sheet Arrangements

In accordance with the definition under SEC rules, the following qualify as off-balance sheet arrangements:

- any obligation under certain guarantees or contracts;
- a retained or contingent interest in assets transferred to an unconsolidated entity or similar entity or similar arrangement that serves as credit, liquidity, or market risk support to that entity for such assets;
- any obligation under certain derivative instruments; and
- any obligation under a material variable interest held by the registrant in an unconsolidated entity that provides financing, liquidity, market risk, or credit risk support to the registrant, or engages in leasing, hedging, or research and development services with the registrant.

As of December 31, 2014, we do not have any material off-balance sheet arrangements.

As part of our ongoing business, we do not participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities ("SPEs"), which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2014, we are not involved in any unconsolidated SPE transactions.

Critical Accounting Estimates

Our consolidated financial statements are prepared in accordance with GAAP. In connection with the preparation of our financial statements, we are required to make assumptions and estimates about future events and apply judgments that affect the reported amounts of assets, liabilities, revenue, expenses, and the related disclosures. We base our assumptions, estimates, and judgments on historical experience, current trends, and other factors we believe to be relevant at the time we prepared our consolidated financial statements. On a regular basis, we review the accounting policies, assumptions, estimates, and judgments to ensure our consolidated financial statements are presented fairly and in accordance with GAAP. However, because future events and their effects cannot be determined with certainty, actual results could differ from our assumptions and estimates, and such differences could be material.

Our significant accounting policies are discussed in Note 1, *Summary of Significant Accounting Policies*, to the accompanying consolidated financial statements. We believe the following accounting estimates are the most critical to aid in fully understanding and evaluating our reported financial results, as they require our most difficult, subjective, or complex judgments, resulting from the need to make estimates about the effect of matters that are inherently uncertain. We have reviewed these critical accounting estimates and related disclosures with the audit committee of our board of directors.

See also Note 2, *Business Combinations*, to the accompanying consolidated financial statements.

Revenue Recognition

We recognize net patient service revenue in the reporting period in which we perform the service based on our current billing rates (i.e., gross charges) less actual adjustments and estimated discounts for contractual allowances (principally for patients covered by Medicare, Medicaid, and managed care and other health plans). See Note 1, *Summary of Significant Accounting Policies*, "Net Operating Revenues," to the accompanying consolidated financial statements for a complete discussion of our revenue recognition policies.

Our patient accounting system calculates contractual allowances on a patient-by-patient basis based on the rates in effect for each primary third-party payor. Other factors that are considered and could further influence the level of our reserves include the patient's total length of stay for in-house patients, each patient's discharge destination, the proportion of patients with secondary insurance coverage and the level of reimbursement under that secondary coverage, and the amount of charges that will be disallowed by payors. Such additional factors are assumed to remain consistent with the experience for patients discharged in similar time periods for the same payor classes, and additional reserves are provided to account for these factors.

Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms that result from contract renegotiations and renewals. In addition, laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

In addition, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. In connection with CMS approved and announced RAC audits related to IRFs, we received requests in 2013 and 2014 to review certain patient files for discharges occurring from 2010 to 2014. To date, the Medicare payments that are subject to these audit requests represent less than 1% of our Medicare patient discharges during those years, and not all of these patient file requests have resulted in payment denial determinations by the RACs. While we make provisions for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs, we cannot provide assurance as to our future success in the resolution of these and future disputes, nor can we predict or estimate the scope or number of denials that ultimately may be received. During 2014 and 2013, we reduced our *Net operating revenues* by approximately $0.4 million and $8 million, respectively, for post-payment claims that are part of this review process.

Due to complexities involved in determining amounts ultimately due under reimbursement arrangements with third-party payors, which are often subject to interpretation and review, we may receive reimbursement for healthcare services authorized and provided that is different from our estimates, and such differences could be material. However, we continually review the amounts actually collected in subsequent periods in order to determine the amounts by which our estimates differed. Historically, such differences have not been material from either a quantitative or qualitative perspective.

Allowance for Doubtful Accounts

The collection of outstanding receivables from third-party payors and patients is our primary source of cash and is critical to our operating performance. We provide for accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. See Note 1, *Summary of Significant Accounting Policies*, "Accounts Receivable and the Allowance for Doubtful Accounts," and Note 4, *Accounts Receivable*, to the accompanying consolidated financial statements for a complete discussion of our policies related to the allowance for doubtful accounts.

We estimate our allowance for doubtful accounts based on the aging of our accounts receivable, our historical collection experience for each type of payor, and other relevant factors so that the remaining receivables, net of allowances, are reflected at their estimated net realizable values. Changes in general economic conditions (such as increased unemployment rates or periods of recession), business office operations, payor mix, or trends in federal or state governmental and private employer healthcare coverage could affect our collection of accounts receivable. Our collection risks include patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and co-payments) remain outstanding. In addition, reimbursement claims made by health care providers are subject to audit from time to time by governmental payors and their agents.

For several years, under programs designated as "widespread probes," certain of our MACs have conducted pre-payment claim reviews of our billing and denied payment for certain diagnosis codes based on medical necessity. We dispute, or "appeal," most of these denials, and we collect approximately 63% of all amounts denied. For claims we choose to take through all levels of appeal, up to and including administrative law judge hearings, we have historically experienced an approximate 72% success rate. Because we do not write off receivables until all collection efforts have been exhausted, we do not write-off receivables related to denied claims while they are in this review process. The resolution of these disputes can take in excess of two years.

If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. As of December 31, 2014 and 2013, $62.2 million and $22.5 million, or 15.4% and 7.5%, respectively, of our patient accounts receivable represented denials by MACs that were in the pre-payment medical necessity review process. During the years ended December 31, 2014, 2013, and 2012, we wrote off $1.4 million, $2.2 million, and $2.3 million, respectively, of previously denied claims while we collected $7.1 million, $1.7 million, and $4.3 million, respectively, of previously denied claims.

The table below shows a summary of our net accounts receivable balances as of December 31, 2014 and 2013. Information on the concentration of total patient accounts receivable by payor class can be found in Note 1, *Summary of Significant Accounting Policies*, "Accounts Receivable and the Allowance for Doubtful Accounts," to the accompanying consolidated financial statements.

	As of December 31,	
	2014	2013
	(In Millions)	
0 - 30 Days	$ 220.6	$ 194.1
31 - 60 Days	33.0	21.7
61 - 90 Days	19.1	10.2
91 - 120 Days	4.1	3.4
120 + Days	32.5	20.0
Current patients accounts receivable, net	309.3	249.4
Noncurrent patient accounts receivable, net	51.4	16.6
Other accounts receivable	13.9	12.4
Accounts receivable, net	**$ 374.6**	**$ 278.4**

Self-Insured Risks

We are self-insured for certain losses related to professional liability, general liability, and workers' compensation risks. Although we obtain third-party insurance coverage to limit our exposure to these claims, a substantial portion of our professional liability, general liability, and workers' compensation risks are insured through a wholly owned insurance subsidiary. See Note 9, *Self-Insured Risks*, to the accompanying consolidated financial statements for a more complete discussion of our self-insured risks.

Our self-insured liabilities contain uncertainties because management must make assumptions and apply judgment to estimate the ultimate cost of reported claims and claims incurred but not reported as of the balance sheet date. Our reserves and provisions for professional liability, general liability, and workers' compensation risks are based largely upon semi-annual actuarial calculations prepared by third-party actuaries.

Periodically, we review our assumptions and the valuations provided by third-party actuaries to determine the adequacy of our self-insurance reserves. The following are the key assumptions and other factors that significantly influence our estimate of self-insurance reserves:

- historical claims experience;
- trending of loss development factors;
- trends in the frequency and severity of claims;
- coverage limits of third-party insurance;
- demographic information;
- statistical confidence levels;
- medical cost inflation;
- payroll dollars; and
- hospital patient census.

The time period to resolve claims can vary depending upon the jurisdiction, the nature, and the form of resolution of the claims. The estimation of the timing of payments beyond a year can vary significantly. In addition, if current and future claims differ from historical trends, our estimated reserves for self-insured claims may be significantly affected. Our self-insurance reserves are not discounted.

Given the number of factors used to establish our self-insurance reserves, we believe there is limited benefit to isolating any individual assumption or parameter from the detailed computational process and calculating the impact of changing that single item. Instead, we believe the sensitivity in our reserve estimates is best illustrated by changes in the statistical confidence level used in the computations. Using a higher statistical confidence level increases the estimated self-insurance reserves. The following table shows the sensitivity of our recorded self-insurance reserves to the statistical confidence level (in millions):

Net self-insurance reserves as of December 31, 2014:	
As reported, with 50% statistical confidence level	108.6
With 70% statistical confidence level	116.0

Over the past few years, we have experienced volatility in our estimates of prior year claim reserves due primarily to favorable trends in claims and industry-wide loss development trends. We believe our efforts to improve patient safety and overall quality of care, as well as our efforts to reduce workplace injuries, have helped contain our ultimate claim costs. See Note 9, *Self-Insured Risks*, to the accompanying consolidated financial statements for additional information.

We believe our self-insurance reserves are adequate to cover projected costs. Due to the considerable variability that is inherent in such estimates, there can be no assurance the ultimate liability will not exceed management's estimates. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

Goodwill

Absent any impairment indicators, we evaluate goodwill for impairment as of October 1st of each year. We test goodwill for impairment at the reporting unit level and are required to make certain subjective and complex judgments on a number of matters, including assumptions and estimates used to determine the fair value of our single reporting unit. We assess qualitative factors in our single reporting unit to determine whether it is necessary to perform the first step of the two-step quantitative goodwill impairment test. The quantitative impairment test is required only if we conclude it is more likely than not our reporting unit's fair value is less than its carrying amount.

If, based on our qualitative assessment, we were to believe we must proceed to Step 1, we would determine the fair value of our reporting unit using generally accepted valuation techniques including the income approach and the market approach. We would validate our estimates under the income approach by reconciling the estimated fair value of our reporting unit determined under the income approach to our market capitalization and estimated fair value determined under the market approach. Values from the income approach and market approach would then be evaluated and weighted to arrive at the estimated aggregate fair value of the reporting unit.

The income approach includes the use of our reporting unit's projected operating results and cash flows that are discounted using a weighted-average cost of capital that reflects market participant assumptions. The projected operating results use management's best estimates of economic and market conditions over the forecasted period including assumptions for pricing and volume, operating expenses, and capital expenditures. Other significant estimates and assumptions include cost-saving synergies and tax benefits that would accrue to a market participant under a fair value methodology. The market approach estimates fair value through the use of observable inputs, including the Company's stock price.

See Note 1, *Summary of Significant Accounting Policies*, "Goodwill and Other Intangibles," and Note 6, *Goodwill and Other Intangible Assets*, to the accompanying consolidated financial statements for additional information.

The following events and circumstances are certain of the qualitative factors we consider in evaluating whether it is more likely than not the fair value of our reporting unit is less than its carrying amount:

- Macroeconomic conditions, such as deterioration in general economic conditions, limitations on accessing capital, or other developments in equity and credit markets;
- Industry and market considerations and changes in healthcare regulations, including reimbursement and compliance requirements under the Medicare and Medicaid programs;
- Cost factors, such as an increase in labor, supply, or other costs;
- Overall financial performance, such as negative or declining cash flows or a decline in actual or forecasted revenue or earnings;

- Other relevant company-specific events, such as material changes in management or key personnel or outstanding litigation;
- Material events, such as a change in the composition or carrying amount of our reporting unit's net assets, including acquisitions and dispositions; and
- Consideration of the relationship of our market capitalization to our book value, as well as a sustained decrease in our share price.

In the fourth quarter of 2014, we performed our annual evaluation of goodwill and determined no adjustment to impair goodwill was necessary. If actual results are not consistent with our assumptions and estimates, we may be exposed to goodwill impairment charges. However, at this time, we continue to believe our reporting unit is not at risk for any impairment charges.

As discussed in the "Results of Operations" section of this Item and Note 2, *Business Combinations,* to the accompanying consolidated financial statements, we will revise our segment reporting in the first quarter of 2015 to report two reportable segments: (1) inpatient rehabilitation and (2) home health and hospice. As a result, beginning in 2015, we will also conduct our annual impairment review of goodwill using these two reporting units.

Income Taxes

We provide for income taxes using the asset and liability method. We also evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. See Note 1, *Summary of Significant Accounting Policies*, "Income Taxes," and Note 16, *Income Taxes*, to the accompanying consolidated financial statements for a more complete discussion of income taxes and our policies related to income taxes.

The application of income tax law is inherently complex. Laws and regulations in this area are voluminous and are often ambiguous. We are required to make many subjective assumptions and judgments regarding our income tax exposures. Interpretations of and guidance surrounding income tax laws and regulations change over time. As such, changes in our subjective assumptions and judgments can materially affect amounts recognized in our consolidated financial statements.

The ultimate recovery of certain of our deferred tax assets is dependent on the amount and timing of taxable income we will ultimately generate in the future, as well as other factors. A high degree of judgment is required to determine the extent a valuation allowance should be provided against deferred tax assets. On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our operating performance in recent years, the scheduled reversal of temporary differences, our forecast of taxable income in future periods in each applicable tax jurisdiction, our ability to sustain a core level of earnings, and the availability of prudent tax planning strategies are important considerations in our assessment. Our forecast of future earnings includes assumptions about patient volumes, payor reimbursement, labor costs, hospital operating expenses, and interest expense. Based on the weight of available evidence, we determine if it is more likely than not our deferred tax assets will be realized in the future.

Our liability for unrecognized tax benefits contains uncertainties because management is required to make assumptions and to apply judgment to estimate the exposures associated with our various filing positions which are periodically audited by tax authorities. In addition, our effective income tax rate is affected by changes in tax law, the tax jurisdictions in which we operate, and the results of income tax audits.

During the year ended December 31, 2014, we decreased our valuation allowance by $7.7 million. As of December 31, 2014, we had a remaining valuation allowance of $23.0 million which related to state NOLs. At the state jurisdiction level, we determined it was necessary to maintain a valuation allowance due to uncertainties related to our ability to utilize a portion of the deferred tax assets before they expire. The amount of the valuation allowance has been determined for each tax jurisdiction based on the weight of all available evidence, as described above, including management's estimates of taxable income for each jurisdiction in which we operate over the periods in which the related deferred tax assets will be recoverable.

While management believes the assumptions included in its forecast of future earnings are reasonable and it is more likely than not the net deferred tax asset balance as of December 31, 2014 will be realized, no such assurances can be provided. If management's expectations for future operating results on a consolidated basis or at the state jurisdiction level vary from actual results due to changes in healthcare regulations, general economic conditions, or other factors, we may need to increase our valuation allowance, or reverse amounts recorded currently in the valuation allowance, for all or a portion of our deferred tax assets. Similarly, future adjustments to our valuation allowance may be necessary if the timing of future tax deductions is different than currently expected. Our income tax expense in future periods will be reduced or increased to the extent of

offsetting decreases or increases, respectively, in our valuation allowance in the period when the change in circumstances occurs. These changes could have a significant impact on our future earnings.

Assessment of Loss Contingencies

We have legal and other contingencies that could result in significant losses upon the ultimate resolution of such contingencies. See Note 1, *Summary of Significant Accounting Policies*, "Litigation Reserves," and Note 18, *Contingencies and Other Commitments*, to the accompanying consolidated financial statements for additional information.

We have provided for losses in situations where we have concluded it is probable a loss has been or will be incurred and the amount of loss is reasonably estimable. A significant amount of judgment is involved in determining whether a loss is probable and reasonably estimable due to the uncertainty involved in determining the likelihood of future events and estimating the financial statement impact of such events. If further developments or resolution of a contingent matter are not consistent with our assumptions and judgments, we may need to recognize a significant charge in a future period related to an existing contingent matter.

Recent Accounting Pronouncements

For information regarding recent accounting pronouncements, see Note 1, *Summary of Significant Accounting Policies*, to the accompanying consolidated financial statements.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

Our primary exposure to market risk is to changes in interest rates on our variable rate long-term debt. We use sensitivity analysis models to evaluate the impact of interest rate changes on our variable rate debt. As of December 31, 2014, our primary variable rate debt outstanding related to $325.0 million in advances under our revolving credit facility and $450.0 million outstanding under our term loan facilities. Assuming outstanding balances were to remain the same, a 1% increase in interest rates would result in an incremental negative cash flow of approximately $5.9 million over the next 12 months, while a 1% decrease in interest rates would result in an incremental positive cash flow of approximately $2.8 million over the next 12 months, assuming floating rate indices are floored at 0%.

The fair value of our fixed rate debt is determined using inputs, including quoted prices in nonactive markets, that are observable either directly or indirectly, or *Level 2* inputs within the fair value hierarchy, and is summarized as follows (in millions):

	December 31, 2014		December 31, 2013	
Financial Instrument:	**Book Value**	**Market Value**	**Book Value**	**Market Value**
7.25% Senior Notes due 2018				
Carrying Value	$ —	$ —	$ 272.4	$ —
Unamortized debt premium	—	—	(1.0)	—
Principal amount	—	—	271.4	291.4
8.125% Senior Notes due 2020				
Carrying Value	287.0	—	286.6	—
Unamortized debt discount	3.0	—	3.4	—
Principal amount	290.0	302.5	290.0	319.4
7.75% Senior Notes due 2022				
Carrying Value	227.1	—	252.5	—
Unamortized debt premium	(1.1)	—	(1.4)	—
Principal amount	226.0	240.7	251.1	275.0
5.75% Senior Notes due 2024				
Carrying Value	456.2	—	275.0	—
Unamortized debt discount	(6.2)	—	—	—
Principal amount	450.0	471.4	275.0	273.6
2.00% Convertible Senior Subordinated Notes due 2043				
Carrying Value	258.0	—	249.5	—
Unamortized debt discount	62.0	—	70.5	—
Principal amount	320.0	358.4	320.0	339.7

Foreign operations, and the related market risks associated with foreign currencies, are currently, and have been, insignificant to our financial position, results of operations, and cash flows.

Item 8. Financial Statements and Supplementary Data

Our consolidated financial statements and related notes are filed together with this report. See the index to financial statements on page F-1 for a list of financial statements filed with this report.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

As of the end of the period covered by this report, an evaluation was carried out by our management, including our chief executive officer and chief financial officer, of the effectiveness of our disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Our disclosure controls and procedures are designed to ensure that information required to be disclosed in reports we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the rules and forms of the Securities and Exchange Commission and that such information is accumulated and communicated to our management, including our chief executive officer and chief financial officer, to allow timely decisions regarding required disclosures. Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2014, our disclosure controls and procedures were effective.

Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act. Internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States of America. Internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the Company's assets that could have a material effect on its financial statements. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions or that the degree of compliance with the policies or procedures may deteriorate.

Under the supervision and with the participation of our management, including our chief executive officer and chief financial officer, we conducted an assessment of the effectiveness of our internal control over financial reporting as of December 31, 2014. In making this assessment, management used the criteria set forth in *Internal Control-Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission, the COSO framework. Based on our evaluation, our chief executive officer and chief financial officer concluded that, as of December 31, 2014, our internal control over financial reporting was effective.

Management has excluded EHHI Holdings, Inc. and its Encompass Home Health and Hospice business ("Encompass") from its assessment of internal control over financial reporting as of December 31, 2014 because it was acquired by the Company in a purchase business combination on December 31, 2014. The total assets of Encompass represent approximately 24% of the related consolidated balance sheet amounts as of December 31, 2014. No revenues for Encompass were included in the consolidated results of operations for the Company for the year ended December 31, 2014.

The effectiveness of the Company's internal control over financial reporting as of December 31, 2014 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which appears herein.

Changes in Internal Control Over Financial Reporting

There were no changes in the Company's internal controls over financial reporting that occurred during the quarter ended December 31, 2014 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

None.

PART III

We expect to file a definitive proxy statement relating to our 2015 Annual Meeting of Stockholders (the "2015 Proxy Statement") with the United States Securities and Exchange Commission, pursuant to Regulation 14A, not later than 120 days after the end of our most recent fiscal year. Accordingly, certain information required by Part III has been omitted under General Instruction G(3) to Form 10-K. Only the information from the 2015 Proxy Statement that specifically addresses disclosure requirements of Items 10-14 below is incorporated by reference.

Item 10. Directors and Executive Officers of the Registrant

The information required by Item 10 is hereby incorporated by reference from our 2015 Proxy Statement under the captions "Items of Business Requiring Your Vote—Proposal 1—Election of Directors," "Corporate Governance and Board Structure—Code of Ethics," "Corporate Governance and Board Structure—Proposals for Director Nominees by Stockholders," "Corporate Governance and Board Structure—Audit Committee," "Section 16(a) Beneficial Ownership Reporting Compliance," and "Executive Officers."

Item 11. Executive Compensation

The information required by Item 11 is hereby incorporated by reference from our 2015 Proxy Statement under the captions "Corporate Governance and Board Structure—Compensation of Directors," "Compensation Committee Matters," and "Executive Compensation."

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Equity Compensation Plans

The following table sets forth, as of December 31, 2014, information concerning compensation plans under which our securities are authorized for issuance. The table does not reflect grants, awards, exercises, terminations, or expirations since that date. All share amounts and exercise prices have been adjusted to reflect stock splits that occurred after the date on which any particular underlying plan was adopted, to the extent applicable.

	Securities to be Issued Upon Exercise	Weighted Average Price[1]	Securities Available for Future Issuance
Plans approved by stockholders	4,185,278 [2]	$ 20.37	3,602,753 [3]
Plans not approved by stockholders	851,532 [4]	21.76	—
Total	5,036,810		3,602,753

(1) This calculation does not take into account awards of restricted stock, restricted stock units, or performance share units.

(2) This amount assumes maximum performance by performance-based awards for which the performance has not yet been determined.

(3) This amount represents the number of shares available for future equity grants under the Amended and Restated 2008 Equity Incentive Plan approved by our stockholders in May 2011.

(4) This amount includes (a) 757,673 and 7,029 shares issuable upon exercise of stock options outstanding under the 2005 Equity Incentive Plan and the Key Executive Incentive Program, respectively, and (b) 86,830 restricted stock units issued under the 2004 Amended and Restated Director Incentive Plan.

2004 Amended and Restated Director Incentive Plan

The 2004 Amended and Restated Director Incentive Plan (the "2004 Plan") provided for the grant of common stock, awards of restricted common stock, and the right to receive awards of common stock, which we refer to as "restricted stock units," to our nonemployee directors. The 2004 Plan expired in March 2008 and was replaced by the 2008 Equity Incentive Plan. Some awards remain outstanding. Awards granted under the 2004 Plan at the time of its termination will continue in effect in accordance with their terms. Awards of restricted stock units were fully vested when awarded and will be settled in shares of common stock on the earlier of the six-month anniversary of the date on which the director ceases to serve on the

board of directors or certain change in control events. The restricted stock units generally cannot be transferred. Awards are generally protected against dilution upon the issuance of stock dividends and in the event of a stock split, recapitalization, or other major corporate restructuring.

2005 Equity Incentive Plan

The 2005 Equity Incentive Plan (the "2005 Plan") provided for the grant of stock options, restricted stock, stock appreciation rights, deferred stock, and other stock-based awards to our directors, executives, and other key employees as determined by the board of directors or the compensation committee in accordance with the terms of the 2005 Plan and evidenced by an award agreement with each participant. The 2005 Plan expired in November 2008 and was replaced by the 2008 Equity Incentive Plan. Some option awards remain outstanding and are fully vested. Awards granted under the 2005 Plan at the time of its termination will continue in effect in accordance with their terms. The outstanding options have an exercise price not less than the fair market value of such shares of common stock on the date of grant and an expiration date that is ten years after the grant date. Awards are generally protected against dilution upon the issuance of stock dividends and in the event of a stock split, recapitalization, or other major corporate restructuring.

Key Executive Incentive Program

On November 17, 2005, our board of directors adopted the Key Executive Incentive Program, which was a response to unusual employee retention needs we were experiencing at that particular time and served as a means of ensuring management continuity during the Company's strategic repositioning expected to continue through 2008. The associated equity awards, which were made on November 17, 2005, were one-time special equity grants designed to keep key members of our management team intact and to be an effective deterrent to officers leaving the Company during our transition phase. Some option awards remain outstanding and are fully vested. The options vested 25% in January 2007, 25% in January 2008, and the remaining 50% in January 2009. The outstanding options have an exercise price not less than the fair market value of such shares of common stock on the date of grant and an expiration date that is ten years after the grant date. Awards are generally protected against dilution upon the issuance of stock dividends and in the event of a stock split, recapitalization, or other major corporate restructuring.

Security Ownership of Certain Beneficial Owners and Management

The other information required by Item 12 is hereby incorporated by reference from our 2015 Proxy Statement under the caption "Security Ownership of Certain Beneficial Owners and Management."

Item 13. Certain Relationships and Related Transactions and Director Independence

The information required by Item 13 is hereby incorporated by reference from our 2015 Proxy Statement under the captions "Corporate Governance and Board Structure—Director Independence" and "Certain Relationships and Related Transactions."

Item 14. Principal Accountant Fees and Services

The information required by Item 14 is hereby incorporated by reference from our 2015 Proxy Statement under the caption "Items of Business Requiring Your Vote—Proposal 2—Ratification of Appointment of Independent Registered Public Accounting Firm."

PART IV

Item 15. Exhibits and Financial Statement Schedules

Financial Statements

See the accompanying index on page F-1 for a list of financial statements filed as part of this report.

Financial Statement Schedules

None.

Exhibits

See Exhibit Index immediately following page F-70 of this report.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this Report to be signed on its behalf by the undersigned, thereunto duly authorized.

HEALTHSOUTH CORPORATION

By: /s/ JAY GRINNEY

Jay Grinney
President and Chief Executive Officer

Date: February 27, 2015

[Signatures continue on the following page]

POWER OF ATTORNEY

Each person whose signature appears below hereby constitutes and appoints John P. Whittington his true and lawful attorney-in-fact and agent with full power of substitution and re-substitution, for him in his name, place and stead, in any and all capacities, to sign any and all amendments to this Report and to file the same, with all exhibits thereto, and other documents in connection therewith, with the Securities and Exchange Commission, and hereby grants to such attorney-in-fact and agent, full power and authority to do and perform each and every act and thing requisite and necessary to be done, as fully to all intents and purposes as he might or could do in person, hereby ratifying and confirming all that said attorney-in-fact and agent or his substitute or substitutes may lawfully do or cause to be done by virtue hereof.

Pursuant to the requirements of the Securities Exchange Act of 1934, this Report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signature	Capacity	Date
/s/ JAY GRINNEY **Jay Grinney**	President and Chief Executive Officer and Director	February 27, 2015
/s/ DOUGLAS E. COLTHARP **Douglas E. Coltharp**	Executive Vice President and Chief Financial Officer	February 27, 2015
/s/ ANDREW L. PRICE **Andrew L. Price**	Chief Accounting Officer	February 27, 2015
/s/ LEO I. HIGDON, JR. **Leo I. Higdon, Jr.**	Chairman of the Board of Directors	February 27, 2015
/s/ JOHN W. CHILDSEY **John W. Childsey**	Director	February 27, 2015
/s/ DONALD L. CORRELL **Donald L. Correll**	Director	February 27, 2015
/s/ YVONNE M. CURL **Yvonne M. Curl**	Director	February 27, 2015
/s/ CHARLES M. ELSON **Charles M. Elson**	Director	February 27, 2015
/s/ JOAN E. HERMAN **Joan E. Herman**	Director	February 27, 2015
/s/ LESLYE G. KATZ **Leslye G. Katz**	Director	February 27, 2015
/s/ JOHN E. MAUPIN, JR. **John E. Maupin, Jr.**	Director	February 27, 2015
/s/ L. EDWARD SHAW, JR. **L. Edward Shaw, Jr.**	Director	February 27, 2015

Item 15. Financial Statements

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of HealthSouth Corporation:

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of operations, comprehensive income, shareholders' equity and cash flows present fairly, in all material respects, the financial position of HealthSouth Corporation and its subsidiaries (the "Company") at December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2014 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As described in Management's Report on Internal Control over Financial Reporting, management has excluded EHHI Holdings, Inc. ("Encompass") from its assessment of internal control over financial reporting as of December 31, 2014 because it was acquired by the Company in a purchase business combination on December 31, 2014. We have also excluded Encompass from our audit of internal control over financial reporting. Encompass is a subsidiary of HealthSouth Corporation whose total assets represent approximately 24% of the related consolidated financial statement amount as of December 31, 2014.

/s/ PricewaterhouseCoopers LLP
Birmingham, Alabama
February 27, 2015

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Operations

	For the Year Ended December 31,		
	2014	2013	2012
	(In Millions, Except Per Share Data)		
Net operating revenues	$ 2,405.9	$ 2,273.2	$ 2,161.9
Less: Provision for doubtful accounts	(31.6)	(26.0)	(27.0)
Net operating revenues less provision for doubtful accounts	2,374.3	2,247.2	2,134.9
Operating expenses:			
Salaries and benefits	1,161.7	1,089.7	1,050.2
Other operating expenses	351.6	323.0	303.8
Occupancy costs	41.6	47.0	48.6
Supplies	111.9	105.4	102.4
General and administrative expenses	124.8	119.1	117.9
Depreciation and amortization	107.7	94.7	82.5
Government, class action, and related settlements	(1.7)	(23.5)	(3.5)
Professional fees—accounting, tax, and legal	9.3	9.5	16.1
Total operating expenses	1,906.9	1,764.9	1,718.0
Loss on early extinguishment of debt	13.2	2.4	4.0
Interest expense and amortization of debt discounts and fees	109.2	100.4	94.1
Other income	(31.2)	(4.5)	(8.5)
Equity in net income of nonconsolidated affiliates	(10.7)	(11.2)	(12.7)
Income from continuing operations before income tax expense	386.9	395.2	340.0
Provision for income tax expense	110.7	12.7	108.6
Income from continuing operations	276.2	382.5	231.4
Income (loss) from discontinued operations, net of tax	5.5	(1.1)	4.5
Net income	281.7	381.4	235.9
Less: Net income attributable to noncontrolling interests	(59.7)	(57.8)	(50.9)
Net income attributable to HealthSouth	222.0	323.6	185.0
Less: Convertible perpetual preferred stock dividends	(6.3)	(21.0)	(23.9)
Less: Repurchase of convertible perpetual preferred stock	—	(71.6)	(0.8)
Net income attributable to HealthSouth common shareholders	$ 215.7	$ 231.0	$ 160.3
Weighted average common shares outstanding:			
Basic	86.8	88.1	94.6
Diluted	100.7	102.1	108.1
Earnings per common share:			
Basic earnings per share attributable to HealthSouth common shareholders:			
Continuing operations	$ 2.40	$ 2.59	$ 1.62
Discontinued operations	0.06	(0.01)	0.05
Net income	$ 2.46	$ 2.58	$ 1.67
Diluted earnings per share attributable to HealthSouth common shareholders:			
Continuing operations	$ 2.24	$ 2.59	$ 1.62
Discontinued operations	0.05	(0.01)	0.05
Net income	$ 2.29	$ 2.58	$ 1.67
Cash dividends per common share	$ 0.78	$ 0.36	$ —
Amounts attributable to HealthSouth common shareholders:			
Income from continuing operations	$ 216.5	$ 324.7	$ 180.5
Income (loss) from discontinued operations, net of tax	5.5	(1.1)	4.5
Net income attributable to HealthSouth	$ 222.0	$ 323.6	$ 185.0

The accompanying notes to consolidated financial statements are an integral part of these statements.

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Comprehensive Income

	For the Year Ended December 31,		
	2014	2013	2012
	(In Millions)		
COMPREHENSIVE INCOME			
Net income	$ 281.7	$ 381.4	$ 235.9
Other comprehensive (loss) income, net of tax:			
Net change in unrealized (loss) gain on available-for-sale securities:			
Unrealized net holding (loss) gain arising during the period	(0.2)	(0.7)	1.6
Reclassifications to net income	(0.5)	(0.9)	—
Other comprehensive (loss) income before income taxes	(0.7)	(1.6)	1.6
Provision for income tax benefit related to other comprehensive (loss) income items	0.3	0.1	—
Other comprehensive (loss) income, net of tax:	(0.4)	(1.5)	1.6
Comprehensive income	281.3	379.9	237.5
Comprehensive income attributable to noncontrolling interests	(59.7)	(57.8)	(50.9)
Comprehensive income attributable to HealthSouth	$ 221.6	$ 322.1	$ 186.6

The accompanying notes to consolidated financial statements are an integral part of these statements.

HealthSouth Corporation and Subsidiaries

Consolidated Balance Sheets

	As of December 31,	
	2014	2013
	(In Millions, Except Share Data)	
Assets		
Current assets:		
Cash and cash equivalents	$ 66.7	$ 64.5
Restricted cash	45.6	52.4
Accounts receivable, net of allowance for doubtful accounts of $22.2 in 2014; $23.1 in 2013	323.2	261.8
Deferred income tax assets	188.4	139.0
Prepaid expenses and other current assets	62.7	62.7
Total current assets	686.6	580.4
Property and equipment, net	1,019.7	910.5
Goodwill	1,084.0	456.9
Intangible assets, net	306.1	88.2
Deferred income tax assets	129.4	354.3
Other long-term assets	183.0	144.1
Total assets	$ 3,408.8	$ 2,534.4
Liabilities and Shareholders' Equity		
Current liabilities:		
Current portion of long-term debt	$ 20.8	$ 12.3
Accounts payable	53.4	61.9
Accrued payroll	123.3	90.8
Accrued interest payable	21.2	23.8
Other current liabilities	145.6	122.8
Total current liabilities	364.3	311.6
Long-term debt, net of current portion	2,110.8	1,505.2
Self-insured risks	98.7	98.2
Other long-term liabilities	37.6	44.0
	2,611.4	1,959.0
Commitments and contingencies		
Convertible perpetual preferred stock, $.10 par value; 1,500,000 shares authorized; 96,245 shares issued in 2014 and 2013; liquidation preference of $1,000 per share	93.2	93.2
Redeemable noncontrolling interests	84.7	13.5
Shareholders' equity:		
HealthSouth shareholders' equity:		
Common stock, $.01 par value; 200,000,000 shares authorized; issued: 104,058,832 in 2014; 102,648,302 in 2013	1.0	1.0
Capital in excess of par value	2,810.5	2,849.4
Accumulated deficit	(1,879.1)	(2,101.1)
Accumulated other comprehensive loss	(0.5)	(0.1)
Treasury stock, at cost (16,270,159 shares in 2014 and 14,654,436 shares in 2013)	(458.7)	(404.6)
Total HealthSouth shareholders' equity	473.2	344.6
Noncontrolling interests	146.3	124.1
Total shareholders' equity	619.5	468.7
Total liabilities and shareholders' equity	$ 3,408.8	$ 2,534.4

The accompanying notes to consolidated financial statements are an integral part of these statements.

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Shareholders' Equity

	HealthSouth Common Shareholders							
	Number of Common Shares Outstanding	Common Stock	Capital in Excess of Par Value	Accumulated Deficit	Accumulated Other Comprehensive (Loss) Income	Treasury Stock	Noncontrolling Interests	Total
	(In Millions)							
December 31, 2011	95.2	$ 1.0	$ 2,874.1	$ (2,609.7)	$ (0.2)	$ (148.8)	$ 84.6	$ 201.0
Net income	—	—	—	185.0	—	—	47.1	232.1
Receipt of treasury stock	(0.7)	—	—	—	—	(11.9)	—	(11.9)
Dividends declared on convertible perpetual preferred stock	—	—	(23.9)	—	—	—	—	(23.9)
Stock-based compensation	—	—	24.1	—	—	—	—	24.1
Distributions declared	—	—	—	—	—	—	(45.4)	(45.4)
Capital contributions from consolidated affiliates	—	—	—	—	—	—	12.4	12.4
Consolidation of St. Vincent Rehabilitation Hospital	—	—	—	—	—	—	13.9	13.9
Other	1.2	—	2.3	—	1.6	(2.6)	(0.1)	1.2
December 31, 2012	95.7	1.0	2,876.6	(2,424.7)	1.4	(163.3)	112.5	403.5
Net income	—	—	—	323.6	—	—	52.0	375.6
Receipt of treasury stock	(0.3)	—	—	—	—	(5.8)	—	(5.8)
Dividends declared on common stock	—	—	(32.0)	—	—	—	—	(32.0)
Dividends declared on convertible perpetual preferred stock	—	—	(21.0)	—	—	—	—	(21.0)
Stock-based compensation	—	—	24.8	—	—	—	—	24.8
Stock options exercised	0.3	—	8.2	—	—	—	—	8.2
Stock warrants exercised	0.5	—	15.3	—	—	—	—	15.3
Distributions declared	—	—	—	—	—	—	(40.4)	(40.4)
Repurchases of common stock through tender offer	(9.1)	—	—	—	—	(234.1)	—	(234.1)
Repurchase of preferred stock through convertible exchange	—	—	(71.6)	—	—	—	—	(71.6)
Equity portion of convertible debt	—	—	71.0	—	—	—	—	71.0
Tax impact of equity portion of convertible debt	—	—	(28.0)	—	—	—	—	(28.0)
Other	0.9	—	6.1	—	(1.5)	(1.4)	—	3.2
December 31, 2013	88.0	1.0	2,849.4	(2,101.1)	(0.1)	(404.6)	124.1	468.7
Net income	—	—	—	**222.0**	—	—	**53.1**	**275.1**
Receipt of treasury stock	**(0.3)**	—	—	—	—	**(9.7)**	—	**(9.7)**
Dividends declared on common stock	—	—	**(69.0)**	—	—	—	—	**(69.0)**
Dividends declared on convertible perpetual preferred stock	—	—	**(6.3)**	—	—	—	—	**(6.3)**
Stock-based compensation	—	—	**23.9**	—	—	—	—	**23.9**
Stock options exercised	**0.3**	—	**7.5**	—	—	**(0.1)**	—	**7.4**
Stock warrants exercised	**0.2**	—	**6.3**	—	—	—	—	**6.3**
Distributions declared	—	—	—	—	—	—	**(44.9)**	**(44.9)**
Repurchases of common stock in open market	**(1.3)**	—	—	—	—	**(43.1)**	—	**(43.1)**
Consolidation of Fairlawn Rehabilitation Hospital	—	—	—	—	—	—	**14.0**	**14.0**
Other	**0.9**	—	**(1.3)**	—	**(0.4)**	**(1.2)**	—	**(2.9)**
December 31, 2014	**87.8**	**$ 1.0**	**$ 2,810.5**	**$ (1,879.1)**	**$ (0.5)**	**$ (458.7)**	**$ 146.3**	**$ 619.5**

The accompanying notes to consolidated financial statements are an integral part of these statements.

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Cash Flows

	For the Year Ended December 31,		
	2014	2013	2012
	(In Millions)		
Cash flows from operating activities:			
Net income	$ 281.7	$ 381.4	$ 235.9
(Income) loss from discontinued operations, net of tax	(5.5)	1.1	(4.5)
Adjustments to reconcile net income to net cash provided by operating activities—			
Provision for doubtful accounts	31.6	26.0	27.0
Provision for government, class action, and related settlements	(1.7)	(23.5)	(3.5)
Depreciation and amortization	107.7	94.7	82.5
Amortization of debt-related items	12.7	5.0	3.7
Loss on early extinguishment of debt	13.2	2.4	4.0
Equity in net income of nonconsolidated affiliates	(10.7)	(11.2)	(12.7)
Distributions from nonconsolidated affiliates	12.6	11.4	11.0
Stock-based compensation	23.9	24.8	24.1
Deferred tax expense	97.4	6.4	102.7
Gain on consolidation of Fairlawn	(27.2)	—	—
Other	4.8	4.3	(0.7)
(Increase) decrease in assets—			
Accounts receivable	(91.6)	(55.1)	(51.3)
Prepaid expenses and other assets	6.5	(4.8)	0.6
Increase (decrease) in liabilities—			
Accounts payable	5.4	6.4	(4.4)
Other liabilities	(10.4)	4.6	(3.0)
Premium received on bond issuance	6.3	—	—
Premium paid on redemption of bonds	(10.6)	(1.7)	(1.9)
Net cash (used in) provided by operating activities of discontinued operations	(1.2)	(1.9)	2.0
Total adjustments	168.7	87.8	180.1
Net cash provided by operating activities	444.9	470.3	411.5
Cash flows from investing activities:			
Acquisition of businesses, net of cash acquired	(694.8)	(28.9)	(3.1)
Purchases of property and equipment	(170.9)	(195.2)	(140.8)
Capitalized software costs	(17.0)	(21.3)	(18.9)
Proceeds from sale of restricted investments	0.3	16.9	0.3
Proceeds from sale of Digital Hospital	—	10.8	—
Purchases of restricted investments	(3.5)	(9.2)	(9.1)
Net change in restricted cash	6.8	(3.1)	(14.0)
Other	2.2	0.5	(0.9)
Net cash provided by investing activities of discontinued operations	—	3.3	7.7
Net cash used in investing activities	(876.9)	(226.2)	(178.8)

(Continued)

HealthSouth Corporation and Subsidiaries

Consolidated Statements of Cash Flows (Continued)

	For the Year Ended December 31,		
	2014	2013	2012
		(In Millions)	
Cash flows from financing activities:			
Principal borrowings on term loan facilities	450.0	—	—
Proceeds from bond issuance	175.0	—	275.0
Principal payments on debt, including pre-payments	(302.6)	(62.5)	(166.2)
Principal borrowings on notes	—	15.2	—
Borrowings on revolving credit facility	440.0	197.0	135.0
Payments on revolving credit facility	(160.0)	(152.0)	(245.0)
Principal payments under capital lease obligations	(6.1)	(10.1)	(12.1)
Repurchases of common stock, including fees and expenses	(43.1)	(234.1)	—
Repurchases of convertible perpetual preferred stock, including fees	—	(2.8)	(46.0)
Dividends paid on common stock	(65.8)	(15.7)	—
Dividends paid on convertible perpetual preferred stock	(6.3)	(23.0)	(24.6)
Distributions paid to noncontrolling interests of consolidated affiliates	(54.1)	(46.3)	(49.3)
Contributions from consolidated affiliates	—	1.6	10.5
Proceeds from exercising stock warrants	6.3	15.3	—
Other	0.9	5.0	(7.3)
Net cash provided by (used in) financing activities	434.2	(312.4)	(130.0)
Increase (decrease) in cash and cash equivalents	2.2	(68.3)	102.7
Cash and cash equivalents at beginning of year	64.5	132.8	30.1
Cash and cash equivalents at end of year	$ 66.7	$ 64.5	$ 132.8
Supplemental cash flow information:			
Cash (paid) received during the year for —			
Interest	$ (100.6)	$ (99.4)	$ (88.1)
Income tax refunds	1.3	4.8	2.2
Income tax payments	(17.7)	(12.5)	(11.8)
Supplemental schedule of noncash investing and financing activities:			
Convertible debt issued	$ —	$ 320.0	$ —
Repurchase of preferred stock	—	(320.0)	—
Equity rollover from Encompass management	64.5	—	—

The accompanying notes to consolidated financial statements are an integral part of these statements.

1. Summary of Significant Accounting Policies:

Organization and Description of Business—

HealthSouth Corporation, incorporated in Delaware in 1984, including its subsidiaries, is the largest owner and operator of inpatient rehabilitation hospitals in the United States in terms of patients treated and discharged, revenues, and number of hospitals. We operate inpatient rehabilitation hospitals and provide specialized rehabilitative treatment on both an inpatient and outpatient basis. While our national network of inpatient hospitals stretches across 29 states and Puerto Rico, our inpatient hospitals are concentrated in the eastern half of the United States and Texas. As of December 31, 2014, we operated 107 inpatient rehabilitation hospitals (including one hospital that operates as a joint venture which we account for using the equity method of accounting). We are the sole owner of 75 of these hospitals. We retain 50.0% to 97.5% ownership in the remaining 32 jointly owned hospitals. In addition to HealthSouth hospitals, we manage three inpatient rehabilitation units through management contracts.

As discussed in Note 2, *Business Combinations*, on December 31, 2014, we completed the acquisition of EHHI Holdings, Inc. ("EHHI") and its Encompass Home Health and Hospice business ("Encompass"). With the acquisition of Encompass, HealthSouth is one of the nation's largest providers of post-acute healthcare services, offering both facility-based and home-based post-acute services in 33 states and Puerto Rico through its network of inpatient rehabilitation hospitals, home health agencies, and hospice agencies.

Basis of Presentation and Consolidation—

The accompanying consolidated financial statements of HealthSouth and its subsidiaries were prepared in accordance with generally accepted accounting principles in the United States of America and include the assets, liabilities, revenues, and expenses of all wholly owned subsidiaries, majority-owned subsidiaries over which we exercise control, and, when applicable, entities in which we have a controlling financial interest.

We use the equity method to account for our investments in entities we do not control, but where we have the ability to exercise significant influence over operating and financial policies. Consolidated *Net income attributable to HealthSouth* includes our share of the net earnings of these entities. The difference between consolidation and the equity method impacts certain of our financial ratios because of the presentation of the detailed line items reported in the consolidated financial statements for consolidated entities compared to a one line presentation of equity method investments.

We use the cost method to account for our investments in entities we do not control and for which we do not have the ability to exercise significant influence over operating and financial policies. In accordance with the cost method, these investments are recorded at the lower of cost or fair value, as appropriate.

We also consider the guidance for consolidating variable interest entities.

We eliminate all significant intercompany accounts and transactions from our financial results.

Use of Estimates and Assumptions—

The preparation of our consolidated financial statements in conformity with GAAP requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting periods. Significant estimates and assumptions are used for, but not limited to: (1) allowance for contractual revenue adjustments; (2) allowance for doubtful accounts; (3) fair value of acquired assets and assumed liabilities in business combinations; (4) asset impairments, including goodwill; (5) depreciable lives of assets; (6) useful lives of intangible assets; (7) economic lives and fair value of leased assets; (8) income tax valuation allowances; (9) uncertain tax positions; (10) fair value of stock options and restricted stock containing a market condition; (11) fair value of redeemable noncontrolling interests; (12) reserves for self-insured healthcare plans; (13) reserves for professional, workers' compensation, and comprehensive general insurance liability risks; and (14) contingency and litigation reserves. Future events and their effects cannot be predicted with certainty; accordingly, our accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of our consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is

obtained, and as our operating environment changes. We evaluate and update our assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Risks and Uncertainties—

As a healthcare provider, we are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These laws and regulations relate to, among other things:

- licensure, certification, and accreditation;
- policies, either at the national or local level, delineating what conditions must be met to qualify for reimbursement under Medicare (also referred to as coverage requirements);
- coding and billing for services;
- requirements of the 60% compliance threshold under The Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007;
- relationships with physicians and other referral sources, including physician self-referral and anti-kickback laws;
- quality of medical care;
- use and maintenance of medical supplies and equipment;
- maintenance and security of patient information and medical records;
- acquisition and dispensing of pharmaceuticals and controlled substances; and
- disposal of medical and hazardous waste.

In the future, changes in these laws or regulations or the manner in which they are enforced could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our hospitals, equipment, personnel, services, capital expenditure programs, operating procedures, contractual arrangements, and patient admittance practices, as well as the way in which we deliver home health and hospice services.

If we fail to comply with applicable laws and regulations, we could be required to return portions of reimbursements deemed after the fact to have not been appropriate. We could also be subjected to liabilities, including (1) criminal penalties, (2) civil penalties, including monetary penalties and the loss of our licenses to operate one or more of our hospitals or agencies, and (3) exclusion or suspension of one or more of our hospitals from participation in the Medicare, Medicaid, and other federal and state healthcare programs which, if lengthy in duration and material to us, could potentially trigger a default under our credit agreement. Because Medicare comprises a significant portion of our *Net operating revenues*, it is important for us to remain compliant with the laws and regulations governing the Medicare program and related matters including anti-kickback and anti-fraud requirements. Reductions in reimbursements, substantial damages, and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operation, and cash flows. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation.

Historically, the United States Congress and some state legislatures have periodically proposed significant changes in regulations governing the healthcare system. Many of these changes have resulted in limitations on the increases in and, in some cases, significant roll-backs or reductions in the levels of payments to healthcare providers for services under many government reimbursement programs. There can be no assurance that future governmental initiatives will not result in pricing roll-backs or freezes or reimbursement reductions. Because we receive a significant percentage of our revenues from Medicare, such changes in legislation might have a material adverse effect on our financial position, results of operations, and cash flows.

Pursuant to legislative directives and authorizations from Congress, the United States Centers for Medicare and Medicaid Services ("CMS") developed and instituted various Medicare audit programs. We undertake significant efforts

through training and education to ensure compliance with coding and medical necessity coverage rules. Despite our belief that our coding and assessment of patients is accurate, audits may lead to assertions that we have been underpaid or overpaid by Medicare or submitted improper claims in some instances, require us to incur additional costs to respond to requests for records and defend the validity of payments and claims, and ultimately require us to refund any amounts determined to have been overpaid. We cannot predict when or how these programs will affect us.

In addition, there are increasing pressures from many third-party payors to control healthcare costs and to reduce or limit increases in reimbursement rates for medical services. Our relationships with managed care and nongovernmental third-party payors are generally governed by negotiated agreements. These agreements set forth the amounts we are entitled to receive for our services. We could be adversely affected in some of the markets where we operate if we are unable to negotiate and maintain favorable agreements with third-party payors.

Our third-party payors may also, from time to time, request audits of the amounts paid, or to be paid, to us. We could be adversely affected in some of the markets where we operate if the auditing payor alleges substantial overpayments were made to us due to coding errors or lack of documentation to support medical necessity determinations.

As discussed in Note 18, *Contingencies and Other Commitments*, we are a party to a number of lawsuits. We cannot predict the outcome of litigation filed against us. Substantial damages or other monetary remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows.

Net Operating Revenues—

We derived consolidated *Net operating revenues* from the following payor sources:

	For the Year Ended December 31,		
	2014	2013	2012
Medicare	74.1%	74.5%	73.4%
Medicaid	1.8%	1.2%	1.2%
Workers' compensation	1.2%	1.2%	1.5%
Managed care and other discount plans, including Medicare Advantage	18.6%	18.5%	19.3%
Other third-party payors	1.8%	1.8%	1.8%
Patients	1.0%	1.1%	1.3%
Other income	1.5%	1.7%	1.5%
Total	100.0%	100.0%	100.0%

We recognize net patient service revenues in the reporting period in which we perform the service based on our current billing rates (i.e., gross charges), less actual adjustments and estimated discounts for contractual allowances (principally for patients covered by Medicare, Medicaid, and managed care and other health plans). We record gross service charges in our accounting records on an accrual basis using our established rates for the type of service provided to the patient. We recognize an estimated contractual allowance and an estimate of potential subsequent adjustments that may arise from post-payment and other reviews to reduce gross patient charges to the amount we estimate we will actually realize for the service rendered based upon previously agreed to rates with a payor. Our patient accounting system calculates contractual allowances on a patient-by-patient basis based on the rates in effect for each primary third-party payor. Other factors that are considered and could further influence the level of our reserves include the patient's total length of stay for in-house patients, each patient's discharge destination, the proportion of patients with secondary insurance coverage and the level of reimbursement under that secondary coverage, and the amount of charges that will be disallowed by payors. Such additional factors are assumed to remain consistent with the experience for patients discharged in similar time periods for the same payor classes, and additional reserves are provided to account for these factors. Payors include federal and state agencies, including Medicare and Medicaid, managed care health plans, commercial insurance companies, employers, and patients.

Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms that result from contract renegotiations and renewals.

Due to complexities involved in determining amounts ultimately due under reimbursement arrangements with third-party payors, which are often subject to interpretation, we may receive reimbursement for healthcare services authorized and provided that is different from our estimates, and such differences could be material. In addition, laws and regulations governing the Medicare and Medicaid programs are complex, subject to interpretation, and are routinely modified for provider reimbursement. All healthcare providers participating in the Medicare and Medicaid programs are required to meet certain financial reporting requirements. Federal regulations require submission of annual cost reports covering medical costs and expenses associated with the services provided by each hospital to program beneficiaries. Annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to HealthSouth under these reimbursement programs. These audits often require several years to reach the final determination of amounts earned under the programs. If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material.

CMS has been granted authority to suspend payments, in whole or in part, to Medicare providers if CMS possesses reliable information an overpayment, fraud, or willful misrepresentation exists. If CMS suspects payments are being made as the result of fraud or misrepresentation, CMS may suspend payment at any time without providing prior notice to us. The initial suspension period is limited to 180 days. However, the payment suspension period can be extended almost indefinitely if the matter is under investigation by the United States Department of Health and Human Services Office of Inspector General (the "HHS-OIG") or the United States Department of Justice. Therefore, we are unable to predict if or when we may be subject to a suspension of payments by the Medicare and/or Medicaid programs, the possible length of the suspension period, or the potential cash flow impact of a payment suspension. Any such suspension would adversely impact our financial position, results of operations, and cash flows.

Pursuant to legislative directives and authorizations from Congress, CMS has developed and instituted various Medicare audit programs under which CMS contracts with private companies to conduct claims and medical record audits. One type of audit contractor, the Recovery Audit Contractors ("RACs"), began post-payment audit processes in late 2009 for providers in general. In connection with CMS approved and announced RAC audits related to IRFs, we received requests in 2014 and 2013 to review certain patient files for discharges occurring from 2010 to 2014. These post-payment RAC audits are focused on medical necessity requirements for admission to IRFs rather than targeting a specific diagnosis code as in previous pre-payment audits. Medical necessity is a subjective assessment by an independent physician of a patient's ability to tolerate and benefit from intensive multi-disciplinary therapy provided in an IRF setting.

To date, the Medicare payments that are subject to these audit requests represent less than 1% of our Medicare patient discharges from 2010 to 2014, and not all of these patient file requests have resulted in payment denial determinations by the RACs. Because we have confidence in the medical judgment of both the referring and the admitting physicians who assess the treatment needs of their patients, we have appealed substantially all RAC denials arising from these audits using the same process we follow for appealing denials of certain diagnosis codes by Medicare Administrative Contractors ("MACs") (see "Accounts Receivable and Allowance for Doubtful Accounts" below). Due to the delays announced by CMS in the related adjudication process, we believe the resolution of any claims that are subsequently denied as a result of these RAC audits could take in excess of two years. In addition, because we have limited experience with RACs in the context of post-payment reviews of this nature, we cannot provide assurance as to the future success of these disputes. As such, we make provisions for these claims based on our historical experience and success rates in the claims adjudication process, which is the same process we follow for appealing denials of certain diagnosis codes by MACs. Because these reviews involve post-payment claims, there are no corresponding patient receivables in our consolidated balance sheet. As the ultimate results of these audits impact our estimates of amounts determined to be due to HealthSouth under these reimbursement programs, our provision for claims that are part of this post-payment review process are recorded to *Net operating revenues*. During 2014 and 2013, we reduced our *Net operating revenues* by approximately $0.4 million and $8 million, respectively, for post-payment claims that are part of this review process.

Cash and Cash Equivalents—

Cash and cash equivalents include highly liquid investments with maturities of three months or less when purchased. Carrying values of *Cash and cash equivalents* approximate fair value due to the short-term nature of these instruments.

We maintain amounts on deposit with various financial institutions, which may, at times, exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and we have not experienced any losses on such deposits.

Marketable Securities—

We record all equity securities with readily determinable fair values and for which we do not exercise significant influence as available-for-sale securities. We carry the available-for-sale securities at fair value and report unrealized holding gains or losses, net of income taxes, in *Accumulated other comprehensive loss*, which is a separate component of shareholders' equity. We recognize realized gains and losses in our consolidated statements of operations using the specific identification method.

Unrealized losses are charged against earnings when a decline in fair value is determined to be other than temporary. Management reviews several factors to determine whether a loss is other than temporary, such as the length of time a security is in an unrealized loss position, the extent to which fair value is less than cost, the financial condition and near term prospects of the issuer, industry, or geographic area and our ability and intent to hold the security for a period of time sufficient to allow for any anticipated recovery in fair value.

Accounts Receivable and Allowance for Doubtful Accounts—

We report accounts receivable at estimated net realizable amounts from services rendered from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, workers' compensation programs, employers, and patients. Our accounts receivable are geographically dispersed, but a significant portion of our revenues are concentrated by type of payors. The concentration of net patient service accounts receivable by payor class, as a percentage of total net patient service accounts receivable, is as follows:

	As of December 31,	
	2014	2013
Medicare	72.2%	67.4%
Medicaid	1.8%	2.0%
Workers' compensation	1.9%	2.6%
Managed care and other discount plans, including Medicare Advantage	18.5%	22.4%
Other third-party payors	3.8%	4.0%
Patients	1.8%	1.6%
Total	100.0%	100.0%

While revenues and accounts receivable from the Medicare program are significant to our operations, we do not believe there are significant credit risks associated with this government agency. We do not believe there are any other significant concentrations of revenues from any particular payor that would subject us to any significant credit risks in the collection of our accounts receivable.

We provide for accounts receivable that could become uncollectible by establishing an allowance to reduce the carrying value of such receivables to their estimated net realizable value. Additions to the allowance for doubtful accounts are made by means of the *Provision for doubtful accounts*. We write off uncollectible accounts (after exhausting collection efforts) against the allowance for doubtful accounts. Subsequent recoveries are recorded via the *Provision for doubtful accounts*.

The collection of outstanding receivables from Medicare, managed care payors, other third-party payors, and patients is our primary source of cash and is critical to our operating performance. While it is our policy to verify insurance prior to a patient being admitted, there are various exceptions that can occur. Such exceptions include instances where we are (1) unable to obtain verification because the patient's insurance company was unable to be reached or contacted, (2) a determination is made that a patient may be eligible for benefits under various government programs, such as Medicaid, and it takes several days, weeks, or months before qualification for such benefits is confirmed or denied, and (3) the patient is transferred to our

hospital from an acute care hospital without having access to a credit card, cash, or check to pay the applicable patient responsibility amounts (i.e., deductibles and co-payments). Based on our historical collection trends, our primary collection risks relate to patient accounts for which the patient was the primary payor or the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts remain outstanding. Changes in the economy, such as increased unemployment rates or periods of recession, can further exacerbate our ability to collect patient responsibility amounts.

We estimate our allowance for doubtful accounts based on the aging of our accounts receivable, our historical collection experience for each type of payor, and other relevant factors so that the remaining receivables, net of allowances, are reflected at their estimated net realizable values. Accounts requiring collection efforts are reviewed via system-generated work queues that automatically stage (based on age and size of outstanding balance) accounts requiring collection efforts for patient account representatives. Collection efforts include contacting the applicable party (both in writing and by telephone), providing information (both financial and clinical) to allow for payment or to overturn payor decisions to deny payment, and arranging payment plans with self-pay patients, among other techniques. When we determine all in-house efforts have been exhausted or it is a more prudent use of resources, accounts may be turned over to a collection agency. Accounts are written off after all collection efforts (internal and external) have been exhausted.

For several years, under programs designated as "widespread probes," certain of our MACs have conducted pre-payment claim reviews of our billings and denied payment for certain diagnosis codes based on medical necessity. We dispute, or "appeal," most of these denials, and we have historically collected approximately 63% of all amounts denied. For claims we choose to take through all levels of appeal, up to and including administrative law judge hearings, we have historically experienced an approximate 72% success rate. The resolution of these disputes can take in excess of two years, and we cannot provide assurance as to our ongoing and future success of these disputes. As such, we make provisions against these receivables in accordance with our accounting policy that necessarily considers historical collection trends of the receivables in this review process as part of our *Provision for doubtful accounts*. Because we do not write-off receivables until all collection efforts have been exhausted, we do not write-off receivables related to denied claims while they are in this review process. When the amount collected related to denied claims differs from the net amount previously recorded, these collection differences are recorded in the *Provision for doubtful accounts*. As a result, the timing of these denials by MACs and their subsequent collection can create volatility in our *Provision for doubtful accounts*.

If actual results are not consistent with our assumptions and judgments, we may be exposed to gains or losses that could be material. Changes in general economic conditions, business office operations, payor mix, or trends in federal or state governmental and private employer healthcare coverage could affect our collection of accounts receivable, financial position, results of operations, and cash flows.

Property and Equipment—

We report land, buildings, improvements, vehicles, and equipment at cost, net of accumulated depreciation and amortization and any asset impairments. We report assets under capital lease obligations at the lower of fair value or the present value of the aggregate future minimum lease payments at the beginning of the lease term. We depreciate our assets using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured. Useful lives are generally as follows:

	Years
Buildings	10 to 30
Leasehold improvements	2 to 15
Vehicles	5
Furniture, fixtures, and equipment	3 to 10
Assets under capital lease obligations:	
Real estate	15 to 20
Vehicles	3 to 4
Equipment	3 to 5

Maintenance and repairs of property and equipment are expensed as incurred. We capitalize replacements and betterments that increase the estimated useful life of an asset. We capitalize pre-acquisition costs when they are directly identifiable with a specific property, the costs would be capitalizable if the property were already acquired, and acquisition of the property is probable. We capitalize interest expense on major construction and development projects while in progress.

We retain fully depreciated assets in property and accumulated depreciation accounts until we remove them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balances are removed from the respective accounts, and the resulting net amount, less any proceeds, is included as a component of income from continuing operations in the consolidated statements of operations. However, if the sale, retirement, or disposal involves a discontinued operation, the resulting net amount, less any proceeds, is included in the results of discontinued operations.

We account for operating leases by recognizing rents, including any rent holidays, on a straight-line basis over the term of the lease.

Goodwill and Other Intangible Assets—

We are required to test our goodwill and indefinite-lived intangible asset (starting in 2015 as a result of the acquisition of Encompass) for impairment at least annually, absent some triggering event that would accelerate an impairment assessment. Absent any impairment indicators, we perform this impairment testing as of October 1st of each year. We recognize an impairment charge for any amount by which the carrying amount of the asset exceeds its implied fair value. We present an impairment charge as a separate line item within income from continuing operations in the consolidated statements of operations, unless the impairment is associated with a discontinued operation. In that case, we include the impairment charge, on a net-of-tax basis, within the results of discontinued operations.

We assess qualitative factors in our single reporting unit (two reporting units starting in 2015 as a result of the acquisition of Encompass) to determine whether it is necessary to perform the first step of the two-step quantitative impairment test. If, based on this qualitative assessment, we were to believe we must proceed to Step 1, we would determine the fair value of our reporting unit using generally accepted valuation techniques including the income approach and the market approach. The income approach includes the use of our reporting unit's discounted projected operating results and cash flows. This approach includes many assumptions related to pricing and volume, operating expenses, capital expenditures, discount factors, tax rates, etc. Changes in economic and operating conditions impacting these assumptions could result in goodwill impairment in future periods. We reconcile the estimated fair value of our reporting unit to our market capitalization. When we dispose of a hospital, goodwill is allocated to the gain or loss on disposition using the relative fair value methodology.

Starting in 2015 as a result of the acquisition of Encompass, we will also assess qualitative factors related to our indefinite-lived intangible asset to determine whether it is necessary to perform the first step of the two-step quantitative impairment test. If, based on this qualitative assessment, we were to believe we must proceed to Step 1, we would determine the fair value of our indefinite-lived intangible asset using generally accepted valuation techniques including the relief-from-royalty method. This method is a form of the income approach in which value is equated to a series of cash flows and discounted at a risk-adjusted rate. It is based on a hypothetical royalty, calculated as a percentage of forecasted revenue, that we would otherwise be willing to pay to use the asset, assuming it were not already owned. This approach includes assumptions related to pricing and volume, as well as a royalty rate a hypothetical third party would be willing to pay for use of the asset. When making our royalty rate assumption, we look to rates paid in arms-length licensing transactions for assets comparable to our asset.

We amortize the cost of intangible assets with finite useful lives over their respective estimated useful lives to their estimated residual value. As of December 31, 2014, none of our finite useful lived intangible assets has an estimated residual value. We also review these assets for impairment whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount.

The range of estimated useful lives and the amortization basis for our intangible assets, excluding goodwill, are generally as follows:

	Estimated Useful Life and Amortization Basis
Certificates of need	10 to 30 years using straight-line basis
Licenses	10 to 20 years using straight-line basis
Noncompete agreements	2 to 18 years using straight-line basis
Trade names:	
Encompass	indefinite-lived asset
All other	10 to 20 years using straight-line basis
Internal-use software	3 to 7 years using straight-line basis
Market access assets	20 years using accelerated basis

We capitalize the costs of obtaining or developing internal-use software, including external direct costs of material and services and directly related payroll costs. Amortization begins when the internal-use software is ready for its intended use. Costs incurred during the preliminary project and post-implementation stages, as well as maintenance and training costs, are expensed as incurred.

Our market access assets are valued using discounted cash flows under the income approach. The value of the market access assets is attributable to our ability to gain access to and penetrate an acquired facility's historical market patient base. To determine this value, we first develop a debt-free net cash flow forecast under various patient volume scenarios. The debt-free net cash flow is then discounted back to present value using a discount factor, which includes an adjustment for company-specific risk. As noted in the above table, we amortize these assets over 20 years using an accelerated basis that reflects the pattern in which we believe the economic benefits of the market access will be consumed.

Impairment of Long-Lived Assets and Other Intangible Assets—

We assess the recoverability of long-lived assets (excluding goodwill) and identifiable acquired intangible assets with finite useful lives, whenever events or changes in circumstances indicate we may not be able to recover the asset's carrying amount. We measure the recoverability of assets to be held and used by a comparison of the carrying amount of the asset to the expected net future cash flows to be generated by that asset, or, for identifiable intangibles with finite useful lives, by determining whether the amortization of the intangible asset balance over its remaining life can be recovered through undiscounted future cash flows. The amount of impairment of identifiable intangible assets with finite useful lives, if any, to be recognized is measured based on projected discounted future cash flows. We measure the amount of impairment of other long-lived assets (excluding goodwill) as the amount by which the carrying value of the asset exceeds the fair market value of the asset, which is generally determined based on projected discounted future cash flows or appraised values. We classify long-lived assets to be disposed of other than by sale as held and used until they are disposed. We report long-lived assets to be disposed of by sale as held for sale and recognize those assets in the balance sheet at the lower of carrying amount or fair value less cost to sell, and we cease depreciation.

Investments in and Advances to Nonconsolidated Affiliates—

Investments in entities we do not control but in which we have the ability to exercise significant influence over the operating and financial policies of the investee are accounted for under the equity method. Equity method investments are recorded at original cost and adjusted periodically to recognize our proportionate share of the investees' net income or losses after the date of investment, additional contributions made, dividends or distributions received, and impairment losses resulting from adjustments to net realizable value. We record equity method losses in excess of the carrying amount of an investment when we guarantee obligations or we are otherwise committed to provide further financial support to the affiliate.

We use the cost method to account for equity investments for which the equity securities do not have readily determinable fair values and for which we do not have the ability to exercise significant influence. Under the cost method of

accounting, private equity investments are carried at cost and are adjusted only for other-than-temporary declines in fair value, additional investments, or distributions deemed to be a return of capital.

Management periodically assesses the recoverability of our equity method and cost method investments and equity method goodwill for impairment. We consider all available information, including the recoverability of the investment, the earnings and near-term prospects of the affiliate, factors related to the industry, conditions of the affiliate, and our ability, if any, to influence the management of the affiliate. We assess fair value based on valuation methodologies, as appropriate, including discounted cash flows, estimates of sales proceeds, and external appraisals, as appropriate. If an investment or equity method goodwill is considered to be impaired and the decline in value is other than temporary, we record an appropriate write-down.

Financing Costs—

We amortize financing costs using the effective interest method over the expected life of the related debt. The related expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of operations.

We accrete discounts and amortize premiums using the effective interest method over the expected life of the related debt, and we report discounts or premiums as a direct deduction from, or addition to, the face amount of the financing. The related income or expense is included in *Interest expense and amortization of debt discounts and fees* in our consolidated statements of operations.

Fair Value Measurements—

Fair value is an exit price, representing the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants. As such, fair value is a market-based measurement that should be determined based on assumptions market participants would use in pricing an asset or liability.

The basis for these assumptions establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

- *Level 1* – Observable inputs such as quoted prices in active markets;
- *Level 2* – Inputs, other than quoted prices in active markets, that are observable either directly or indirectly; and
- *Level 3* – Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions.

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- *Market approach* – Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities;
- *Cost approach* – Amount that would be required to replace the service capacity of an asset (i.e., replacement cost); and
- *Income approach* – Techniques to convert future cash flows to a single present amount based on market expectations (including present value techniques, option-pricing models, and lattice models).

Our financial instruments consist mainly of cash and cash equivalents, restricted cash, restricted marketable securities, accounts receivable, accounts payable, letters of credit, and long-term debt. The carrying amounts of cash and cash equivalents, restricted cash, accounts receivable, and accounts payable approximate fair value because of the short-term maturity of these instruments. The fair value of our letters of credit is deemed to be the amount of payment guaranteed on our behalf by third-party financial institutions. We determine the fair value of our long-term debt using quoted market prices, when available, or discounted cash flows based on various factors, including maturity schedules, call features, and current market rates.

On a recurring basis, we are required to measure our available-for-sale restricted marketable securities. The fair values of our available-for-sale restricted marketable securities are determined based on quoted market prices in active markets or quoted prices, dealer quotations, or alternative pricing sources supported by observable inputs in markets that are not considered to be active.

On a nonrecurring basis, we are required to measure property and equipment, goodwill, other intangible assets, investments in nonconsolidated affiliates, and assets and liabilities of discontinued operations at fair value. Generally, assets are recorded at fair value on a nonrecurring basis as a result of impairment charges or similar adjustments made to the carrying value of the applicable assets. The fair value of our property and equipment is determined using discounted cash flows and significant unobservable inputs, unless there is an offer to purchase such assets, which could be the basis for determining fair value. The fair value of our intangible assets, excluding goodwill, is determined using discounted cash flows and significant unobservable inputs. The fair value of our investments in nonconsolidated affiliates is determined using quoted prices in private markets, discounted cash flows or earnings, or market multiples derived from a set of comparables. The fair value of our assets and liabilities of discontinued operations is determined using discounted cash flows and significant unobservable inputs unless there is an offer to purchase such assets and liabilities, which would be the basis for determining fair value. The fair value of our goodwill is determined using discounted projected operating results and cash flows, which involve significant unobservable inputs.

See also the "Redeemable Noncontrolling Interests" section of this note.

Noncontrolling Interests in Consolidated Affiliates—

The consolidated financial statements include all assets, liabilities, revenues, and expenses of less-than-100%-owned affiliates we control. Accordingly, we have recorded noncontrolling interests in the earnings and equity of such entities. We record adjustments to noncontrolling interests for the allocable portion of income or loss to which the noncontrolling interests holders are entitled based upon their portion of the subsidiaries they own. Distributions to holders of noncontrolling interests are adjusted to the respective noncontrolling interests holders' balance.

Convertible Perpetual Preferred Stock—

Our *Convertible perpetual preferred stock* contains fundamental change provisions that allow the holder to require us to redeem the preferred stock for cash if certain events occur. As redemption under these provisions is not solely within our control, we have classified our *Convertible perpetual preferred stock* as temporary equity.

Because our *Convertible perpetual preferred stock* is indexed to, and potentially settled in, our common stock, we also examined whether the embedded conversion option in our *Convertible perpetual preferred stock* should be bifurcated. Based on our analysis, we determined bifurcation is not necessary.

Redeemable Noncontrolling Interests—

Certain of our joint venture agreements contain provisions that allow our partners to require us to purchase their interests in the joint venture at fair value at certain points in the future. Likewise, and as discussed in Note 2, *Business Combinations*, certain members of Encompass management hold similar put rights regarding their interests in our home health and hospice business. Because these noncontrolling interests provide for redemption features that are not solely within our control, we classify them as *Redeemable noncontrolling interests* outside of permanent equity in our consolidated balance sheets. At the end of each reporting period, we compare the carrying value of the *Redeemable noncontrolling interests* to their estimated redemption value. If the estimated redemption value is greater than the current carrying value, the carrying value is adjusted to the estimated redemption value, with the adjustments recorded through equity in the line item *Capital in excess of par value*.

The fair value of our *Redeemable noncontrolling interests* in our joint venture hospitals is determined primarily using the income approach. The income approach includes the use of the hospital's projected operating results and cash flows discounted using a rate that reflects market participant assumptions for the applicable hospitals, or *Level 3* inputs. The projected operating results use management's best estimates of economic and market conditions over the forecasted periods including assumptions for pricing and volume, operating expenses, and capital expenditures.

Share-Based Payments—

HealthSouth has shareholder-approved stock-based compensation plans that provide for the granting of stock-based compensation to certain employees and directors. All share-based payments to employees, including grants of employee stock options, are recognized in the financial statements based on their estimated grant-date fair value and amortized on a straight-line basis over the applicable requisite service period.

Litigation Reserves—

We accrue for loss contingencies associated with outstanding litigation for which management has determined it is probable a loss contingency exists and the amount of loss can be reasonably estimated. If the accrued amount associated with a loss contingency is greater than $5.0 million, we also accrue estimated future legal fees associated with the loss contingency. This requires management to estimate the amount of legal fees that will be incurred in the defense of the litigation. These estimates are based on our expectations of the scope, length to complete, and complexity of the claims. In the future, additional adjustments may be recorded as the scope, length, or complexity of outstanding litigation changes.

Advertising Costs—

We expense costs of print, radio, television, and other advertisements as incurred. Advertising expenses, primarily included in *Other operating expenses* within the accompanying consolidated statements of operations, were $5.3 million, $5.2 million, and $5.0 million in each of the years ended December 31, 2014, 2013, and 2012, respectively.

Professional Fees—Accounting, Tax, and Legal—

In 2014, 2013, and 2012, *Professional fees—accounting, tax, and legal* related primarily to legal and consulting fees for continued litigation and support matters discussed in Note 18, *Contingencies and Other Commitments*. These expenses in 2012 also included legal and consulting fees for the pursuit of our remaining income tax benefits, as discussed in Note 16, *Income Taxes*.

Income Taxes—

We provide for income taxes using the asset and liability method. This approach recognizes the amount of income taxes payable or refundable for the current year, as well as deferred tax assets and liabilities for the future tax consequence of events recognized in the consolidated financial statements and income tax returns. Deferred income tax assets and liabilities are adjusted to recognize the effects of changes in tax laws or enacted tax rates.

A valuation allowance is required when it is more likely than not some portion of the deferred tax assets will not be realized. Realization is dependent on generating sufficient future taxable income in the applicable tax jurisdiction. On a quarterly basis, we assess the likelihood of realization of our deferred tax assets considering all available evidence, both positive and negative. Our most recent operating performance, the scheduled reversal of temporary differences, our forecast of taxable income in future periods by jurisdiction, our ability to sustain a core level of earnings, and the availability of prudent tax planning strategies are important considerations in our assessment.

We evaluate our tax positions and establish assets and liabilities in accordance with the applicable accounting guidance on uncertainty in income taxes. We review these tax uncertainties in light of changing facts and circumstances, such as the progress of tax audits, and adjust them accordingly.

We use the with-and-without method to determine when we will recognize excess tax benefits from stock-based compensation. Under this method, we recognize these excess tax benefits only after we fully realize the tax benefits of net operating losses.

HealthSouth and its corporate subsidiaries file a consolidated federal income tax return. Some subsidiaries consolidated for financial reporting purposes are not part of the consolidated group for federal income tax purposes and file separate federal income tax returns. State income tax returns are filed on a separate, combined, or consolidated basis in accordance with relevant state laws and regulations. Partnerships, limited liability companies, and other pass-through entities we consolidate or account for using the equity method of accounting file separate federal and state income tax returns. We

include the allocable portion of each pass-through entity's income or loss in our federal income tax return. We allocate the remaining income or loss of each pass-through entity to the other partners or members who are responsible for their portion of the taxes.

Assets and Liabilities in and Results of Discontinued Operations—

Components of an entity that have been disposed of or are classified as held for sale and have operations and cash flows that can be clearly distinguished from the rest of the entity are reported as discontinued operations. In the period a component of an entity has been disposed of or classified as held for sale, we reclassify the results of operations for current and prior periods into a single caption titled *Income (loss) from discontinued operations, net of tax*. In addition, we classify the assets and liabilities of those components as current and noncurrent assets and liabilities within *Prepaid expenses and other current assets*, *Other long-term assets*, *Other current liabilities*, and *Other long-term liabilities* in our consolidated balance sheets. We also classify cash flows related to discontinued operations as one line item within each category of cash flows in our consolidated statements of cash flows.

Earnings per Common Share—

The calculation of earnings per common share is based on the weighted-average number of our common shares outstanding during the applicable period. The calculation for diluted earnings per common share recognizes the effect of all potential dilutive common shares, including warrants, that were outstanding during the respective periods, unless their impact would be antidilutive. The calculation of earnings per common share also considers the effect of participating securities. Stock-based compensation awards that contain nonforfeitable rights to dividends and dividend equivalents, such as our nonvested restricted stock awards granted before 2014 and restricted stock units, are considered participating securities and are included in the computation of earnings per common share pursuant to the two-class method. In applying the two-class method, earnings are allocated to both common stock shares and participating securities based on their respective weighted-average shares outstanding for the period.

We use the if-converted method to include our *Convertible perpetual preferred stock* and convertible senior subordinated notes in our computation of diluted earnings per share. All other potential dilutive shares, including warrants, are included in our weighted-average diluted share count using the treasury stock method.

Treasury Stock—

Shares of common stock repurchased by us are recorded at cost as treasury stock. When shares are reissued, we use an average cost method to determine cost. The difference between the cost of the shares and the re-issuance price is added to or deducted from *Capital in excess of par value*. We account for the retirement of treasury stock as a reduction of retained earnings. However, due to our *Accumulated deficit*, the retirement of treasury stock is currently recorded as a reduction of *Capital in excess of par value*.

Comprehensive Income—

Comprehensive income is comprised of *Net income* and changes in unrealized gains or losses on available-for-sale securities and is included in the consolidated statements of comprehensive income.

Recent Accounting Pronouncements—

In April 2014, the Financial Accounting Standards Board (the "FASB") issued a new standard that changes the criteria for determining which disposals should be presented as discontinued operations and modifies related disclosure requirements. Under the previous standard, any component that had been disposed of or was classified as held for sale would have qualified for discontinued operations reporting unless there was significant continuing involvement with the disposed component or continuing cash flows. In contrast, the new standard requires the disposal of the component, or group of components, represent a strategic shift that has, or will have, a major effect on the entity's operations and financial results in order to qualify as a discontinued operation. As a result, the sale or disposal of a single HealthSouth facility will no longer qualify as a discontinued operation. The new guidance is effective for disposal transactions or new components classified as held for sale beginning January 1, 2015.

In May 2014, the FASB updated its revenue recognition standard to clarify the principles for recognizing revenue and eliminate industry-specific guidance. In addition, the updated standard revises current disclosure requirements in an effort to help financial statement users better understand the nature, amount, timing, and uncertainty of revenue that is recognized. This revised standard will be effective for HealthSouth for the annual reporting period beginning on January 1, 2017, including interim periods within that year. Early adoption is not permitted. We continue to review the requirements of this revised standard and any potential impact it may have on our financial position, results of operations, or cash flows. It will require us to reclassify our *Provision for doubtful accounts* from a component of *Net operating revenues* to operating expenses.

We do not believe any other recently issued, but not yet effective, accounting standards will have a material effect on our consolidated financial position, results of operations, or cash flows.

2. Business Combinations:

Encompass Acquisition

On December 31, 2014, we completed the acquisition of EHHI and its Encompass Home Health and Hospice business. Encompass provides home health and hospice services out of 135 locations across 12 states. In the acquisition, we acquired all of the issued and outstanding equity interests of EHHI, other than equity interests contributed to HealthSouth Home Health Holdings, Inc. ("Holdings"), a subsidiary of HealthSouth and now indirect parent of EHHI, by certain sellers in exchange for shares of common stock of Holdings. These certain sellers, who are members of Encompass management, including April Anthony, the Chief Executive Officer of Encompass, contributed a portion of their shares of common stock of EHHI, valued at approximately $64.5 million, in exchange for shares of common stock of Holdings. As a result of that contribution, they hold approximately 16.7% of the outstanding common stock of Holdings, while HealthSouth owns the remainder. In addition, Ms. Anthony and certain other employees of Encompass entered into amended and restated employment agreements, each agreement having an initial term of three years. We funded the cash purchase price in the acquisition entirely with draws under the revolving and expanded term loan facilities of our credit agreement. See Note 8, *Long-term Debt*.

This acquisition was made to enhance our position and expand our ability to provide post-acute healthcare services to patients. We expect approximately 23% of the goodwill resulting from this transaction to be deductible for federal income tax purposes. The goodwill reflects our expectations of favorable growth opportunities in the home health and hospice markets based on positive demographic trends.

We accounted for this transaction under the acquisition method of accounting. Because the acquisition took place on December 31, 2014, our consolidated results of operations do not include any results of operations from Encompass. Assets acquired, liabilities assumed, and redeemable noncontrolling interests were recorded at their estimated fair values as of the acquisition date. Estimated fair values were based on various valuation methodologies including: replacement cost and continued use methods for property and equipment; an income approach using primarily discounted cash flow techniques for amortizable intangible assets; an income approach utilizing the relief-from-royalty method for the indefinite-lived intangible asset; and an estimated realizable value approach using historical trends and other relevant information for accounts receivable and certain accrued liabilities. For all other assets and liabilities, the fair value was assumed to represent carrying value due to their short maturities. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill.

The fair values recorded were based upon a preliminary valuation. Estimates and assumptions used in such valuation are subject to change, which could be significant, within the measurement period (up to one year from the acquisition date). The primary areas of the preliminary valuation that are not yet finalized relate to the fair values of amounts for income taxes, adjustments to working capital, and the final amount of residual goodwill. We expect to continue to obtain information to assist us in determining the fair values of the net assets acquired at the acquisition date during the measurement period.

The preliminary fair value of the assets acquired and liabilities assumed at the acquisition date were as follows (in millions):

Cash and cash equivalents	$ 20.9
Accounts receivable, net	37.6
Prepaid expenses and other current assets	8.6
Property and equipment, net	9.6
Identifiable intangible assets:	
Noncompete agreements (useful life of 2 to 5 years)	5.6
Trade name (indefinite life)	135.2
Licenses (useful life of 10 years)	58.2
Internal-use software (useful life of 3 years)	3.2
Goodwill	592.5
Other long-term assets	2.1
Total assets acquired	873.5
Current portion of long-term debt	2.0
Accounts payable	0.9
Accrued payroll	25.8
Other current liabilities	18.5
Long-term debt, net of current portion	2.0
Deferred tax liabilities	64.3
Total liabilities assumed	113.5
Redeemable noncontrolling interests	64.5
Net assets acquired	$ 695.5

Because the noncontrolling interests included in this acquisition include redemption features that are not solely within our control, they are included in *Redeemable noncontrolling interests* in our consolidated balance sheet as of December 31, 2014. Beginning in the first quarter of 2015, the fair value of the *Redeemable noncontrolling interests* related to Encompass will be determined using the product of a twelve-month specified performance measure for Holdings and a specified median market price multiple based on a basket of public home health companies. See Note 11, *Redeemable Noncontrolling Interests*.

In conjunction with this acquisition, we granted stock appreciation rights ("SARs") based on Holdings' common stock to certain members of Encompass management at closing on December 31, 2014. We granted 122,976 SARs that vest based on continued employment and an additional 129,124 SARs that vest based on continued employment and the extent of Encompass' attainment of a target 2017 specified performance measure. In general terms, half of the SARs of each type will vest on December 31, 2018 with the remainder vesting on December 31, 2019. The SARs that ultimately vest will expire on the tenth anniversary of the grant date or within a specified period following any earlier termination of employment. Upon exercise, each SAR must be settled for cash in the amount by which the per share fair value of Holdings' common stock on the exercise date exceeds the agreed upon per share fair value on the acquisition date. The fair value of Holdings' common stock is determined using the product of the trailing 12-month specified performance measure for Holdings and a specified median market price multiple based on a basket of public home health companies.

Information regarding the net cash paid for the acquisition of Encompass is as follows (in millions):

Fair value of assets acquired, net of $20.9 million of cash acquired	$ 260.1
Goodwill	592.5
Fair value of liabilities assumed	(113.5)
Redeemable noncontrolling interests	(64.5)
Net cash paid for acquisition	$ 674.6

As a result of the acquisition of Encompass, in the first quarter of 2015, management changed the way it manages and operates the consolidated reporting entity and modified the reports used by its chief operating decision maker to assess performance and allocate resources. These changes will require us to revise our segment reporting from our historic presentation of only one reportable segment. Beginning in the first quarter of 2015, we will manage our operations and disclose financial information using two reportable segments: (1) inpatient rehabilitation and (2) home health and hospice.

Other Acquisitions

In June 2014, using cash on hand, we acquired an additional 30% equity interest from UMass Memorial Health Care, our joint venture partner in Fairlawn Rehabilitation Hospital ("Fairlawn") in Worcester, Massachusetts. This transaction increased our ownership interest from 50% to 80% and resulted in a change in accounting for this hospital from the equity method of accounting to a consolidated entity. As a result of our consolidation of this hospital and the remeasurement of our previously held equity interest at fair value, *Goodwill* increased by $34.0 million, and we recorded a $27.2 million gain as part of *Other income* during 2014. The Fairlawn transaction was made to increase our ownership in a profitable hospital and continue to grow our core business by consolidating its operations. None of the goodwill resulting from this transaction is deductible for federal income tax purposes. See also Note 16, *Income Taxes*.

In November 2014, we acquired 50.1% of the James H. & Cecile C. Quillen Rehabilitation Hospital ("Quillen"), a 26-bed inpatient rehabilitation hospital in Johnson City, Tennessee, through a joint venture with Mountain States Health Alliance. The joint venture, which was funded using cash on hand, was not material to our financial position, results of operations, or cash flows. The Quillen transaction was made to enhance our position and ability to provide inpatient rehabilitative services to patients in Johnson City and its surrounding areas. As a result of this transaction, *Goodwill* increased by $0.6 million, none of which is deductible for federal income tax purposes. The noncontrolling interest associated with this agreement includes redemption features that are not solely within our control and, therefore, is considered *Redeemable noncontrolling interests*. See Note 11, *Redeemable Noncontrolling Interests*.

In April 2013, we closed the transaction to acquire Walton Rehabilitation Hospital, a 58-bed inpatient rehabilitation hospital in Augusta, Georgia. This acquisition was made to enhance our position and ability to provide inpatient rehabilitative services to patients in Augusta, Georgia and its surrounding areas. The acquisition, which was funded using availability under our revolving credit facility, was not material to our financial position, results of operations, or cash flows. As a result of this transaction, *Goodwill* increased by $13.7 million, all of which is deductible for federal income tax purposes.

In April 2012, we acquired 12 inpatient rehabilitation beds in Andalusia, Alabama from a subsidiary of LifePoint Hospitals in order to add beds at our existing hospital in Dothan, Alabama. In July 2012, we acquired the 34-bed inpatient rehabilitation unit of CHRISTUS Santa Rosa Hospital - Medical Center. The operations of this unit have been relocated to and consolidated with our existing hospital in San Antonio, Texas. Both transactions were made to enhance our position and ability to provide inpatient rehabilitative services to patients in the respective areas. These transactions, either individually or in the aggregate, were not material to our financial position, results of operations, or cash flows. *Goodwill* did not increase as a result of these transactions. Both acquisitions were funded with available cash.

We accounted for all of these transactions under the acquisition method of accounting and reported the results of operations of the acquired or newly consolidated hospitals from their respective dates of acquisition. Assets acquired and liabilities assumed were recorded at their estimated fair values as of the respective acquisition dates. The fair values of identifiable intangible assets were based on valuations using the cost and income approaches. The cost approach is based on amounts that would be required to replace the asset (i.e., replacement cost). The income approach is based on management's

estimates of future operating results and cash flows discounted using a weighted-average cost of capital that reflects market participant assumptions. The excess of the fair value of the consideration conveyed over the fair value of the net assets acquired was recorded as goodwill. The goodwill reflects our expectations of our ability to gain access to and penetrate the acquired or consolidated hospitals' historical patient base and the benefits of being able to leverage operational efficiencies with favorable growth opportunities based on positive demographic trends in these markets.

The fair value of the assets acquired and liabilities assumed at the acquisition dates for the Fairlawn and Quillen transactions completed in 2014 were as follows (in millions):

Total current assets	$ 12.1
Property and equipment, net	36.9
Identifiable intangible assets:	
Noncompete agreements (useful lives of 2 to 3 years)	0.4
Trade names (useful lives of 20 years)	2.9
Certificates of need (useful lives of 20 years)	10.8
Licenses (useful lives of 20 years)	2.1
Goodwill	34.6
Total assets acquired	99.8
Total current liabilities assumed	(7.8)
Total long-term liabilities assumed	(13.4)
Net assets acquired	$ 78.6

Information regarding the net cash paid for all other acquisitions during each period presented is as follows (in millions):

	For the Year Ended December 31,		
	2014	2013	2012
Fair value of assets acquired, net of $5.1 million of cash acquired in 2014	$ 60.1	$ 15.6	$ 3.1
Goodwill	34.6	13.7	—
Fair value of liabilities assumed	(21.2)	(0.4)	—
Fair value of noncontrolling interest owned by joint venture partner	(18.3)	—	—
Fair value of equity interest prior to acquisition	(35.0)	—	—
Net cash paid for acquisitions	$ 20.2	$ 28.9	$ 3.1

See also Note 7, *Investments in and Advances to Nonconsolidated Affiliates.*

Pro Forma Results of Operations

The following table summarizes the results of operations of the above mentioned transactions from their respective dates of acquisition included in our consolidated results of operations and the unaudited pro forma results of operations of the combined entity had the date of the acquisitions been January 1, 2013 (in millions):

	Net Operating Revenues	Net Income Attributable to HealthSouth
Acquired entities only: Actual from acquisition date to December 31, 2014*	$ 27.2	$ 4.0
Combined entity: Supplemental pro forma from 1/01/2014-12/31/2014 (unaudited)	2,799.8	237.5
Combined entity: Supplemental pro forma from 1/01/2013-12/31/2013 (unaudited)	2,627.6	311.3

* Encompass - Actual amounts are zero due to the acquisition of Encompass on December 31, 2014.
Fairlawn - includes operating results from June 1, 2014 through December 31, 2014
Quillen - includes operating results from November 1, 2014 through December 31, 2014

The information presented above is for illustrative purposes only and is not necessarily indicative of results that would have been achieved if the acquisitions had occurred as of the beginning of our 2013 reporting period. For the Encompass acquisition, the unaudited pro forma information above includes adjustments for: (1) acquisition costs; (2) amortization of incremental identifiable intangible assets; (3) management fees paid to Encompass' former equity holders; (4) interest on debt incurred to fund the acquisition (see Note 8, *Long-term Debt*); (5) income taxes using a rate of 40%; and (6) noncontrolling interests.

3. Cash and Marketable Securities:

The components of our investments as of December 31, 2014 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 66.7	$ 45.6	$ —	$ 112.3
Equity securities	—	—	50.5	50.5
Total	$ 66.7	$ 45.6	$ 50.5	$ 162.8

The components of our investments as of December 31, 2013 are as follows (in millions):

	Cash & Cash Equivalents	Restricted Cash	Restricted Marketable Securities	Total
Cash	$ 64.5	$ 52.4	$ —	$ 116.9
Equity securities	—	—	47.6	47.6
Total	$ 64.5	$ 52.4	$ 47.6	$ 164.5

Restricted Cash—

As of December 31, 2014 and 2013, *Restricted cash* consisted of the following (in millions):

	As of December 31,	
	2014	2013
Affiliate cash	$ 13.1	$ 13.6
Self-insured captive funds	32.4	37.8
Paid-loss deposit funds	0.1	1.0
Total restricted cash	$ 45.6	$ 52.4

Affiliate cash represents cash accounts maintained by joint ventures in which we participate where one or more of our external partners requested, and we agreed, that the joint venture's cash not be commingled with other corporate cash accounts and be used only to fund the operations of those joint ventures. Self-insured captive funds represent cash held at our wholly owned insurance captive, HCS, Ltd., as discussed in Note 9, *Self-Insured Risks*. These funds are committed to pay third-party administrators for claims incurred and are restricted by insurance regulations and requirements. These funds cannot be used for purposes outside HCS without the permission of the Cayman Islands Monetary Authority. Paid-loss deposit funds represent cash held by third-party administrators to fund expenses and other payments related to claims.

The classification of restricted cash held by HCS as current or noncurrent depends on the classification of the corresponding claims liability. As of December 31, 2014 and 2013, all restricted cash was current.

Marketable Securities—

Restricted marketable securities at both balance sheet dates represent restricted assets held at HCS. HCS insures HealthSouth's professional liability, workers' compensation, and other insurance claims. These funds are committed for payment of claims incurred, and the classification of these marketable securities as current or noncurrent depends on the classification of the corresponding claims liability. As of December 31, 2014 and 2013, $45.9 million and $42.9 million, respectively, of restricted marketable securities are included in *Other long-term assets* in our consolidated balance sheets.

A summary of our restricted marketable securities as of December 31, 2014 is as follows (in millions):

	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Equity securities	$ 51.3	$ 0.5	$ (1.3)	$ 50.5

A summary of our restricted marketable securities as of December 31, 2013 is as follows (in millions):

	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Equity securities	$ 47.9	$ 0.2	$ (0.5)	$ 47.6

Cost in the above tables includes adjustments made to the cost basis of our equity securities for other-than-temporary impairments. During the years ended December 31, 2014, 2013, and 2012, we did not record any impairment charges related to our restricted marketable securities.

Investing information related to our restricted marketable securities is as follows (in millions):

	For the Year Ended December 31,		
	2014	2013	2012
Proceeds from sales of restricted available-for-sale securities	$ —	$ 16.6	$ —
Proceeds from sales of nonrestricted available-for-sale securities	$ 2.7	$ —	$ —
Gross realized gains	$ 0.5	$ 1.0	$ —
Gross realized losses	$ (0.1)	$ (0.1)	$ —

Our portfolio of marketable securities is comprised of investments in mutual funds that hold investments in a variety of industries and geographies. As discussed in Note 1, *Summary of Significant Accounting Policies*, "Marketable Securities," when our portfolio includes marketable securities with unrealized losses that are not deemed to be other-than-temporarily impaired, we examine the severity and duration of the impairments in relation to the cost of the individual investments. We also consider the industry and geography in which each investment is held and the near-term prospects for a recovery in each.

4. Accounts Receivable:

Accounts receivable consists of the following (in millions):

	As of December 31,	
	2014	2013
Current:		
Patient accounts receivable, net of allowance for doubtful accounts of $22.2 million in 2014; $23.1 million in 2013	$ 309.3	$ 249.4
Other accounts receivable	13.9	12.4
	323.2	**261.8**
Noncurrent patient accounts receivable, net of allowance for doubtful accounts of $20.8 million in 2014; $10.0 million in 2013	51.4	16.6
Accounts receivable, net	**$ 374.6**	**$ 278.4**

Because the resolution of claims that are part of Medicare audit programs can take in excess of two years, we review the patient receivables that are part of this adjudication process to determine their appropriate classification as either current or noncurrent. Amounts considered noncurrent are included in *Other long-term assets* in our consolidated balance sheet.

At December 31, 2014 and 2013, our allowance for doubtful accounts represented approximately 10.7% and 11.1%, respectively, of the total patient due accounts receivable balance.

The following is the activity related to our allowance for doubtful accounts (in millions):

For the Year Ended December 31,	Balance at Beginning of Period	Additions and Charges to Expense	Deductions and Accounts Written Off	Balance at End of Period
2014	$ 33.1	$ 31.6	$ (21.7)	$ 43.0
2013	$ 28.7	$ 26.0	$ (21.6)	$ 33.1
2012	$ 21.4	$ 27.0	$ (19.7)	$ 28.7

5. Property and Equipment:

Property and equipment consists of the following (in millions):

	As of December 31,	
	2014	2013
Land	$ 108.1	$ 96.0
Buildings	1,214.4	1,085.2
Leasehold improvements	79.1	65.0
Vehicles	9.3	4.8
Furniture, fixtures, and equipment	364.2	339.6
	1,775.1	1,590.6
Less: Accumulated depreciation and amortization	(784.0)	(712.6)
	991.1	878.0
Construction in progress	28.6	32.5
Property and equipment, net	$ 1,019.7	$ 910.5

As of December 31, 2014, approximately 75% of our consolidated *Property and equipment, net* held by HealthSouth Corporation and its guarantor subsidiaries was pledged to the lenders under our credit agreement. See Note 8, *Long-term Debt*, and Note 20, *Condensed Consolidating Financial Information*.

Information related to fully depreciated assets and assets under capital lease obligations is as follows (in millions):

	As of December 31,	
	2014	2013
Fully depreciated assets	$ 240.9	$ 225.0
Assets under capital lease obligations:		
Buildings	$ 124.4	$ 124.4
Vehicles	5.2	—
Equipment	0.2	0.2
	129.8	124.6
Less: Accumulated amortization	(55.2)	(47.6)
Assets under capital lease obligations, net	$ 74.6	$ 77.0

The amount of depreciation expense, amortization expense relating to assets under capital lease obligations, interest capitalized, and rent expense under operating leases is as follows (in millions):

	For the Year Ended December 31,		
	2014	2013	2012
Depreciation expense	$ 79.9	$ 67.9	$ 59.0
Amortization expense	$ 7.5	$ 9.5	$ 10.1
Interest capitalized	$ 1.5	$ 1.9	$ 1.0
Rent expense:			
Minimum rent payments	$ 37.3	$ 40.3	$ 41.2
Contingent and other rents	18.2	20.3	20.6
Other	3.9	4.2	4.5
Total rent expense	$ 59.4	$ 64.8	$ 66.3

Leases—

We lease certain land, buildings, and equipment under noncancelable operating leases generally expiring at various dates through 2025. We also lease certain buildings and equipment under capital leases generally expiring at various dates through 2034. Operating leases generally have 3- to 15-year terms, with one or more renewal options, with terms to be negotiated at the time of renewal. Various facility leases include provisions for rent escalation to recognize increased operating costs or require us to pay certain maintenance and utility costs. Contingent rents are included in rent expense in the year incurred.

Some facilities are subleased to other parties. Rental income from subleases approximated $5.1 million, $4.9 million, and $4.7 million for the years ended December 31, 2014, 2013, and 2012, respectively. Total expected future minimum rentals under these noncancelable subleases approximated $6.0 million as of December 31, 2014.

Certain leases contain annual escalation clauses based on changes in the Consumer Price Index while others have fixed escalation terms. The excess of cumulative rent expense (recognized on a straight-line basis) over cumulative rent payments made on leases with fixed escalation terms is recognized as straight-line rental accrual and is included in *Other long-term liabilities* in the accompanying consolidated balance sheets, as follows (in millions):

	As of December 31,	
	2014	2013
Straight-line rental accrual	$ 14.6	$ 17.3

In March 2008, we sold our corporate campus to Daniel Corporation ("Daniel"), a Birmingham, Alabama-based real estate company. The sale included a deferred purchase price component related to an incomplete 13-story building located on the property, often referred to as the Digital Hospital. Under the agreement, Daniel was obligated upon sale of its interest in the building to pay to us 40% of the net profit realized from the sale. In June 2013, Daniel sold the building to Trinity Medical Center. In the third quarter of 2013, we received $10.8 million in cash from Daniel in connection with the sale of the building. The gain associated with this transaction is being deferred and amortized over five years, which is the remaining life of our lease agreement with Daniel for the portion of the property we continue to occupy with our corporate office, as a component of *General and administrative expenses*.

Future minimum lease payments at December 31, 2014, for those leases having an initial or remaining noncancelable lease term in excess of one year, are as follows (in millions):

Year Ending December 31,	Operating Leases	Capital Lease Obligations	Total
2015	$ 43.8	$ 15.3	$ 59.1
2016	37.6	15.0	52.6
2017	31.8	14.0	45.8
2018	27.0	13.6	40.6
2019	22.4	10.7	33.1
2020 and thereafter	87.3	98.4	185.7
	$ 249.9	167.0	$ 416.9
Less: Interest portion		(80.3)	
Obligations under capital leases		$ 86.7	

In addition to the above, and as discussed in Note 8, *Long-term Debt*, "Other Notes Payable," we have two sale/leaseback transactions involving real estate accounted for as financings. Future minimum payments, which are accounted for as interest, under these obligations are $2.7 million in each of the next five years and $11.0 million thereafter.

6. Goodwill and Other Intangible Assets:

The following table shows changes in the carrying amount of *Goodwill* for the years ended December 31, 2014, 2013, and 2012 (in millions):

	Amount
Goodwill as of December 31, 2011	$ 421.7
Consolidation of joint venture formerly accounted for under the equity method of accounting	15.6
Goodwill as of December 31, 2012	437.3
Acquisition	13.7
Conversion of 100% owned hospital into a joint venture	6.2
Divestiture of skilled nursing facility beds	(0.3)
Goodwill as of December 31, 2013	456.9
Acquisitions	593.1
Consolidation of joint venture formerly accounted for under the equity method of accounting	34.0
Goodwill as of December 31, 2014	$ 1,084.0

Goodwill increased in 2012 as a result of our consolidation of St. Vincent Rehabilitation Hospital and the remeasurement of our previously held equity interest at fair value. *Goodwill* increased in 2013 as a result of our acquisition of Walton Rehabilitation Hospital and conversion of our 100% owned hospital in Jonesboro, Arkansas into a joint venture with St. Bernards Healthcare offset by the divestiture of 41 skilled nursing facility beds. *Goodwill* increased in 2014 as a result of our consolidation of Fairlawn and the remeasurement of our previously held equity interest at fair value and our acquisitions of Encompass and Quillen. See Note 2, *Business Combinations*, Note 7, *Investments in and Advances to Nonconsolidated Affiliates*, and Note 11, *Redeemable Noncontrolling Interests*.

We performed impairment reviews as of October 1, 2014, 2013, and 2012 and concluded no *Goodwill* impairment existed. As of December 31, 2014, we had no accumulated impairment losses related to *Goodwill*.

The following table provides information regarding our other intangible assets (in millions):

	Gross Carrying Amount	Accumulated Amortization	Net
Certificates of need:			
2014	$ 27.9	$ (4.0)	$ 23.9
2013	14.7	(3.0)	11.7
Licenses:			
2014	$ 110.8	$ (46.3)	$ 64.5
2013	50.5	(44.9)	5.6
Noncompete agreements:			
2014	$ 46.2	$ (29.4)	$ 16.8
2013	40.2	(24.8)	15.4
Trade name - Encompass:			
2014	$ 135.2	$ —	$ 135.2
2013	—	—	—
Trade names - all other:			
2014	$ 19.9	$ (10.1)	$ 9.8
2013	17.0	(9.3)	7.7
Internal-use software:			
2014	$ 125.3	$ (74.5)	$ 50.8
2013	105.3	(63.5)	41.8
Market access assets:			
2014	$ 13.2	$ (8.1)	$ 5.1
2013	13.2	(7.2)	6.0
Total intangible assets:			
2014	$ 478.5	$ (172.4)	$ 306.1
2013	240.9	(152.7)	88.2

Amortization expense for other intangible assets is as follows (in millions):

	For the Year Ended December 31,		
	2014	2013	2012
Amortization expense	$ 20.3	$ 17.3	$ 13.4

Total estimated amortization expense for our other intangible assets for the next five years is as follows (in millions):

Year Ending December 31,	Estimated Amortization Expense
2015	$ 28.5
2016	25.0
2017	20.7
2018	16.8
2019	15.8

7. Investments in and Advances to Nonconsolidated Affiliates:

Investments in and advances to nonconsolidated affiliates as of December 31, 2014 represents our investment in nine partially owned subsidiaries, of which eight are general or limited partnerships, limited liability companies, or joint ventures in which HealthSouth or one of its subsidiaries is a general or limited partner, managing member, member, or venturer, as applicable. We do not control these affiliates but have the ability to exercise significant influence over the operating and financial policies of certain of these affiliates. Our ownership percentages in these affiliates range from approximately 1% to 51%. We account for these investments using the cost and equity methods of accounting. Our investments, which are included in *Other long-term assets* in our consolidated balance sheets, consist of the following (in millions):

	As of December 31,	
	2014	2013
Equity method investments:		
Capital contributions	$ 0.8	$ 2.9
Cumulative share of income	77.3	104.8
Cumulative share of distributions	(69.9)	(88.8)
	8.2	18.9
Cost method investments:		
Capital contributions, net of distributions and impairments	1.2	1.4
Total investments in and advances to nonconsolidated affiliates	$ 9.4	$ 20.3

The following summarizes the combined assets, liabilities, and equity and the combined results of operations of our equity method affiliates (on a 100% basis, in millions):

	As of December 31,	
	2014	2013
Assets—		
Current	$ 9.6	$ 16.6
Noncurrent	13.1	36.2
Total assets	$ 22.7	$ 52.8
Liabilities and equity—		
Current liabilities	$ 0.7	$ 2.4
Noncurrent liabilities	0.1	0.7
Partners' capital and shareholders' equity—		
HealthSouth	8.2	18.9
Outside partners	13.7	30.8
Total liabilities and equity	$ 22.7	$ 52.8

Condensed statements of operations (in millions):

	For the Year Ended December 31,		
	2014	2013	2012
Net operating revenues	$ 50.2	$ 74.3	$ 83.3
Operating expenses	(25.9)	(43.6)	(48.1)
Income from continuing operations, net of tax	30.9	24.6	28.3
Net income	30.9	24.6	28.3

During the third quarter of 2012, we negotiated with our partner to amend the joint venture agreement related to St. Vincent Rehabilitation Hospital which resulted in a change in accounting for this hospital from the equity method of accounting to a consolidated entity. The amendment revised certain participatory rights held by our joint venture partner resulting in HealthSouth gaining control of this entity from an accounting perspective. We accounted for this change in control as a business combination and consolidated this entity using the acquisition method. The consolidation of St. Vincent Rehabilitation Hospital did not have a material impact on our financial position, results of operations, or cash flows. As a result of our consolidation of this hospital and the remeasurement of our previously held equity interest at fair value, *Goodwill* increased by $15.6 million, and we recorded a $4.9 million gain as part of *Other income* during the year ended December 31, 2012. See Note 6, *Goodwill and Other Intangible Assets*, and Note 12, *Fair Value Measurements*.

See also Note 2, *Business Combinations*.

8. Long-term Debt:

Our long-term debt outstanding consists of the following (in millions):

	As of December 31,	
	2014	2013
Credit Agreement—		
Advances under revolving credit facility	$ 325.0	$ 45.0
Term loan facilities	450.0	—
Bonds payable—		
7.25% Senior Notes due 2018	—	272.4
8.125% Senior Notes due 2020	287.0	286.6
7.75% Senior Notes due 2022	227.1	252.5
5.75% Senior Notes due 2024	456.2	275.0
2.00% Convertible Senior Subordinated Notes due 2043	258.0	249.5
Other notes payable	41.6	47.6
Capital lease obligations	86.7	88.9
	2,131.6	1,517.5
Less: Current portion	(20.8)	(12.3)
Long-term debt, net of current portion	$ 2,110.8	$ 1,505.2

The following chart shows scheduled principal payments due on long-term debt for the next five years and thereafter (in millions):

Year Ending December 31,	Face Amount	Net Amount
2015	$ 20.8	$ 20.8
2016	20.4	20.4
2017	18.6	18.6
2018	18.6	18.6
2019	496.7	496.7
Thereafter	1,614.1	1,556.5
Total	$ 2,189.2	$ 2,131.6

During 2014, we:

- issued, in September 2014, an additional $175 million of our 5.75% Senior Notes due 2024 at a price of 103.625% of the principal amount, which resulted in approximately $182 million in net proceeds from the public offering;
- amended, in September and December 2014, our existing credit agreement to, among other things, add $450 million of term loan facility capacity, permit unlimited restricted payments (as defined in the credit agreement) so long as the senior secured leverage ratio remains less than or equal to 1.75x, and extend the revolver maturity from June 2018 to September 2019;
- redeemed, in October 2014, the outstanding principal amount of our 7.25% Senior Notes due 2018 using the net proceeds from the September offering of our 5.75% Senior Notes due 2024, a $75 million draw under our term loan facilities, and cash on hand. Pursuant to the terms of the 7.25% Senior Notes due 2018, this redemption was made at a price of 103.625%, which resulted in a total cash outlay of approximately $281 million to retire the approximate $271 million in principal; and
- redeemed, in December 2014, approximately $25 million of the outstanding principal amount of our existing 7.75% Senior Notes due 2022. Pursuant to the terms of these notes, this optional redemption represented 10% of the outstanding principal amount of the notes at a price of 103%, which resulted in a total cash outlay of approximately $26 million. We used cash on hand for this redemption.

As a result of the above redemptions, we recorded a $13.2 million *Loss on early extinguishment of debt* in 2014.

Additionally, in December 2014, we drew $375 million under our term loan facilities and $325 million under our revolving credit facility to fund the acquisition of Encompass. See Note 2, *Business Combinations*. In January 2015, we issued an additional $400 million of our 5.75% Senior Notes due 2024 at a price of 102% of the principal amount and used $250 million of the net proceeds to repay borrowings under our term loan facilities, with the remaining net proceeds used to repay borrowings under our revolving credit facility. As a result of this transaction, we expect to record an approximate $2 million *Loss on early extinguishment of debt* in the first quarter of 2015.

In November 2013, we redeemed approximately $30 million and approximately $28 million of the outstanding principal amount of our existing 7.25% Senior Notes due 2018 and our existing 7.75% Senior Notes due 2022, respectively. Pursuant to the terms of these senior notes, this optional redemption represented 10% of the outstanding principal amount of the notes at a price of 103%, which resulted in a total cash outlay of approximately $60 million to retire the approximate $58 million in principal. We used a combination of cash on hand and availability under our revolving credit facility for this redemption. As a result of this redemption, we recorded a $2.4 million *Loss on early extinguishment of debt* in 2013. Additionally, in November 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock. See Note 10, *Convertible Perpetual Preferred Stock.*

In September 2012, we completed a registered public offering of $275 million aggregate principal amount of 5.75% Senior Notes due 2024 at a public offering price of 100% of the principal amount, the proceeds of which were used to repay amounts outstanding under our revolving credit facility and redeem 10% of the outstanding principal amount of our existing 7.25% Senior Notes due 2018 and our existing 7.75% Senior Notes due 2022. As a result of these transactions, we recorded a $4.0 million *Loss on early extinguishment of debt* in 2012.

Senior Secured Credit Agreement—

2014 Credit Agreement

In September and December 2014, we amended our existing credit agreement, previously amended on June 11, 2013 (the "Credit Agreement"). The Credit Agreement provides for $450 million of term loan capacity and a $600 million revolving credit facility, with a $260 million letter of credit subfacility and a swingline loan subfacility, all of which mature in September 2019. Amounts drawn under the term loan facilities are payable in equal consecutive quarterly installments, commencing on March 31, 2015, of 1.25% of the aggregate principal amount of the term loans outstanding as of March 31, 2015, with the remainder due at maturity. We have the right at any time to prepay, in whole or in part, any borrowing under the term loan facilities.

Amounts drawn on the term loan facilities and the revolving credit facility bear interest at a rate per annum of, at our option, (1) LIBOR or (2) the higher of (a) Barclays' Bank PLC's ("Barclays") prime rate and (b) the federal funds rate plus 0.5%, in each case, plus an applicable margin that varies depending upon our leverage ratio. We are also subject to a commitment fee of 0.375% per annum on the daily amount of the unutilized commitments under the term loan facilities and revolving credit facility. The initial interest rate on borrowings under the Credit Agreement is LIBOR plus 1.75%.

The Credit Agreement contains affirmative and negative covenants and default and acceleration provisions, including a minimum interest coverage ratio and a maximum leverage ratio that change over time. Under one such negative covenant, we are restricted from paying common stock dividends, prepaying certain senior notes, and repurchasing preferred and common equity unless (1) we are not in default under the terms of the Credit Agreement and (2) our senior secured leverage ratio, as defined in the Credit Agreement, does not exceed 1.75x. In the event the senior secured leverage ratio exceeds 1.75x, these payments are subject to a limit of $200 million plus an amount equal to a portion of excess cash flows each fiscal year. Our obligations under the Credit Agreement are secured by the current and future personal property of the Company and its subsidiary guarantors.

As of December 31, 2014, $325 million were drawn under the revolving credit facility with an interest rate of 2.0%. Amounts drawn as of December 31, 2014 exclude $31.8 million utilized under the letter of credit subfacility, which were being used in the ordinary course of business to secure workers' compensation and other insurance coverages and for general corporate purposes.

In contrast to the revolving credit facility, capacity under the term loan facilities do not replenish upon repayment of amounts drawn. Because the entire $450 million of term loan capacity was drawn as of December 31, 2014, the term loan facilities no longer constitute an additional source of liquidity for us.

The Credit Agreement provides that, subject to the satisfaction of certain conditions, we have the right to increase the amount of the Credit Agreement prior to its maturity by incurring incremental term loans or by increasing the revolving credit facility, or both, in an aggregate amount not to exceed $300 million. We utilized this feature of the Credit Agreement to increase our term loan facilities in December 2014 to fund the acquisition of Encompass. With the January 2015 repayment of $250 million of borrowings under our term loan facilities, as discussed above, this feature of the Credit Agreement is currently limited to $250 million.

2013 Credit Agreement

On June 11, 2013, we amended our existing credit agreement, dated August 10, 2012 (the " 2013 Credit Agreement"). The 2013 Credit Agreement provided for a $600 million revolving credit facility with a $260 million letter of credit subfacility and a swingline loan subfacility, all of which would have matured in June 2018.

The 2013 Credit Agreement contained the same affirmative and negative covenants and default and acceleration provisions as the Credit Agreement except we were restricted from paying common stock dividends, prepaying certain senior notes, and repurchasing preferred and common equity unless our senior secured leverage ratio, as defined in the 2013 Credit Agreement, did not exceed 1.5x. Our obligations under the 2013 Credit Agreement were secured by substantially all of the real and personal property of us and our subsidiary guarantors, including mortgages with respect to certain of our material real property that we owned as of the date of the 2013 Credit Agreement. All other material terms were the same as the Credit Agreement discussed above.

As of December 31, 2013, $45.0 million were drawn under the revolving credit facility with an interest rate of 1.9%. Amounts drawn as of December 31, 2013 excluded $36.5 million utilized under the letter of credit subfacility, which were being used in the ordinary course of business to secure workers' compensation and other insurance coverages and for general corporate purposes.

2012 Credit Agreement

On August 10, 2012, we amended and restated our existing credit agreement, dated May 10, 2011 (the "2012 Credit Agreement"). The 2012 Credit Agreement provided for a $600 million revolving credit facility with a $260 million letter of credit subfacility and a swingline loan subfacility all of which would have matured in August 2017. All other material terms were the same as the 2013 Credit Agreement discussed above. Our obligations under the 2012 Credit Agreement also were secured and guaranteed by us and our subsidiaries.

Bonds Payable—

Nonconvertible Notes

The Company's 2018 Notes, 2020 Notes, 2022 Notes, and 2024 Notes (collectively, the "Senior Notes") were issued pursuant to an indenture (the "Base Indenture") dated as of December 1, 2009 between us and The Bank of Nova Scotia Trust Company of New York, as trustee (the "Original Trustee"), as supplemented by the second, third, and fourth supplemental indenture, respectively, relating to the Senior Notes (together with the Base Indenture, the "Indenture"), among us, the Subsidiary Guarantors (as defined in the Indenture), and the Original Trustee. The Original Trustee notified us of its intention to discontinue its corporate trust operations and, accordingly, to resign upon the appointment of a successor trustee. Effective July 29, 2013, Wells Fargo Bank, National Association, was appointed as successor trustee under the Indenture.

Pursuant to the terms of the Indenture, the Senior Notes are jointly and severally guaranteed on a senior, unsecured basis by all of our existing and future subsidiaries that guarantee borrowings under our Credit Agreement and other capital markets debt (see Note 20, *Condensed Consolidating Financial Information*). The Senior Notes are senior, unsecured obligations of HealthSouth and rank equally with our other senior indebtedness, senior to any of our subordinated indebtedness, and effectively junior to our secured indebtedness to the extent of the value of the collateral securing such indebtedness.

Upon the occurrence of a change in control (as defined in the Indenture), each holder of the Senior Notes may require us to repurchase all or a portion of the notes in cash at a price equal to 101% of the principal amount of the Senior Notes to be repurchased, plus accrued and unpaid interest.

The Senior Notes contain covenants and default and acceleration provisions, that, among other things, limit our and certain of our subsidiaries' ability to (1) incur additional debt, (2) make certain restricted payments, (3) consummate specified asset sales, (4) incur liens, and (5) merge or consolidate with another person.

Senior Notes Due 2018 and 2022

On October 7, 2010, we completed a public offering of $525.0 million aggregate principal amount of senior notes, which included $275.0 million of 7.25% Senior Notes due 2018 (the "2018 Notes") at par and $250.0 million of 7.75% Senior Notes due 2022 (the "2022 Notes") at par (collectively, the "2018 and 2022 Senior Notes"). We used the net proceeds from the initial offering of the 2018 and 2022 Senior Notes to repay amounts outstanding under the term loan facility of our former credit agreement dated March 2006.

On March 7, 2011, we completed a public offering of $120 million aggregate principal amount of senior notes, which included an additional $60 million of the 2018 Notes at 103.25% of the principal amount and an additional $60 million of the 2022 Notes at 103.50% of the principal amount. Net proceeds from this offering were approximately $122 million. We used approximately $45 million of the net proceeds to repay a portion of the amounts outstanding under our revolving credit facility. In June 2011, the remainder of the net proceeds were used to redeem a portion of our former senior notes due 2016 outstanding at that time.

On October 9, 2012, $64.5 million of the net proceeds from our public offering of the 2024 Notes were used to redeem $33.5 million of the outstanding principal amount of our existing 2018 Notes and $31.0 million of the outstanding principal amount of our existing 2022 Notes. The notes were redeemed at a price of 103%, which resulted in an additional cash outlay of $1.9 million from the net proceeds.

On November 29, 2013, we redeemed $30.2 million and $27.9 million of the outstanding principal amount of our existing 2018 Notes and our existing 2022 Notes, respectively. Pursuant to the terms of these senior notes, this optional redemption represented 10% of the outstanding principal amount of the notes at a price of 103%, which resulted in a total cash outlay of approximately $60 million to retire the $58.1 million in principal. We used a combination of cash on hand and availability under our revolving credit facility for this redemption.

On October 1, 2014, we redeemed the remaining $271.4 million outstanding principal amount of our 2018 Notes. Pursuant to the terms of the 2018 Notes, this redemption was made at a price of 103.625%, which resulted in a total cash outlay of approximately $281 million to retire the $271.4 million in principal. We used the net proceeds from the $175 million September offering of our existing 2024 Notes discussed below, a $75 million draw under our term loan facilities, and cash on hand for this redemption. The 2018 Notes would have matured on October 1, 2018. Inclusive of financing costs, the effective interest rate on the 2018 Notes was 7.5%. Interest was payable semiannually in arrears on April 1 and October 1 of each year.

On December 1, 2014, we redeemed $25.1 million of the outstanding principal amount of our existing 2022 Notes. Pursuant to the terms of the 2022 Notes, this optional redemption represented 10% of the outstanding principal amount of the notes at a price of 103%, which resulted in a total cash outlay of approximately $26 million to retire the $25.1 million in principal. We used cash on hand for this redemption.

2022 Notes

The 2022 Notes mature on September 15, 2022 and bear interest at a per annum rate of 7.75%. Inclusive of financing costs, the effective interest rate on the 2022 Notes is 7.9%. Interest is payable semiannually in arrears on March 15 and September 15 of each year.

We may redeem the 2022 Notes, in whole or in part, at any time on or after September 15, 2015, at the redemption prices set forth below:

Period	Redemption Price*
2015	103.875%
2016	102.583%
2017	101.292%
2018 and thereafter	100.000%

* Expressed in percentage of principal amount

Senior Notes Due 2020

In December 2009, we issued $290.0 million of 8.125% Senior Notes due 2020 (the "2020 Notes") at 98.327% of par. We used the net proceeds from this transaction along with cash on hand to tender for and redeem all of our former floating rate senior notes due 2014 outstanding at that time. Due to discounts and financing costs, the effective interest rate on the 2020 Notes is 8.7%. Interest is payable semiannually in arrears on February 15 and August 15 of each year.

We may redeem the 2020 Notes, in whole or in part, at any time on or after February 15, 2015, at the redemption prices set forth below:

Period	Redemption Price*
2015	104.063%
2016	102.708%
2017	101.354%
2018 and thereafter	100.000%

* Expressed in percentage of principal amount

Senior Notes Due 2024

On September 11, 2012, we completed a public offering of $275 million aggregate principal amount of 5.75% Senior Notes due 2024 (the "2024 Notes") at a public offering price of 100% of the principal amount. Net proceeds from this offering were approximately $270 million. We used $195 million of the net proceeds to repay the amounts outstanding under our revolving credit facility. Additionally, in October 2012, $64.5 million of the net proceeds were used to redeem a portion of our 2018 and 2022 Senior Notes.

On September 18, 2014, we issued an additional $175 million of the 2024 Notes at a price of 103.625% of the principal amount, which resulted in approximately $182 million in net proceeds from the public offering. We used the net proceeds to redeem the 2018 Notes, as discussed above.

On January 29, 2015, we issued an additional $400 million of the 2024 Notes at a price of 102% of the principal amount, which resulted in approximately $406 million in net proceeds from the public offering. We used $250 million of the net proceeds to repay borrowings under our term loan facilities, with the remaining net proceeds used to repay borrowings under our revolving credit facility.

The 2024 Notes mature on November 1, 2024 and bear interest at a per annum rate of 5.75%. Inclusive of financing costs, the effective interest rate on the 2024 Notes is 5.8%. Interest is payable semiannually in arrears on May 1 and November 1 of each year.

We may redeem the 2024 Notes, in whole or in part, at any time on or after November 1, 2017, at the redemption prices set forth below:

Period	Redemption Price*
2017	102.875%
2018	101.917%
2019	100.958%
2020 and thereafter	100.000%

* Expressed in percentage of principal amount

Convertible Notes

Convertible Senior Subordinated Notes Due 2043

On November 18, 2013, we exchanged $320 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 (the "Convertible Notes") for 257,110 shares of our outstanding 6.50% Series A Convertible Perpetual Preferred Stock. The Company's Convertible Notes were issued pursuant to an indenture dated November 18, 2013 (the "Convertible Notes Indenture") between us and Wells Fargo Bank, National Association, as trustee and conversion agent. The Convertible Notes are senior subordinated unsecured obligations of the Company. As such, the Convertible Notes are subordinated to all our existing and future senior unsecured debt and are effectively subordinated to our existing and future secured debt to the extent of the value of the collateral securing such debt. Additionally, the Convertible Notes are structurally subordinated to all existing and future debt and other obligations of our subsidiaries.

The Convertible Notes bear regular interest at a rate of 2.0% per year payable semiannually in arrears in cash on June 1 and December 1 of each year. Beginning with the six-month period starting December 1, 2018, contingent interest is payable, in addition to regular interest, if the trading price of the Convertible Notes for each of the five trading days ending two trading days prior to any six-month contingent interest period is equal to or greater than $1,200. The amount of contingent interest payable per $1,000 principal amount of the Convertible Notes in respect of any contingent interest period is equal to 0.25% of the average trading price of the Convertible Notes during the specified measurement period. Due to discounts and financing costs, the effective interest rate on the Convertible Notes is 6.0%.

The Convertible Notes mature on December 1, 2043, unless earlier redeemed, repurchased, or converted. The Convertible Notes are convertible, at the option of the holder, at any time on or prior to the close of business on the business day immediately preceding December 1, 2043 into shares of our common stock at an initial conversion rate of 25.2194 shares per $1,000 principal amount of the Convertible Notes, subject to customary antidilution adjustments. This conversion rate equates to an initial conversion price of $39.652 per share. We may elect to settle any conversion, in whole or in part, by delivering cash in lieu of shares. Upon the occurrence of certain change of control events and a redemption prior to December 2018, in either case, in connection with elections by holders to convert their Convertible Notes, we will pay a make-whole premium on any Convertible Notes converted by increasing the conversion rate on such Convertible Notes.

The payment of dividends on our common stock has triggered and will continue to trigger, from time to time, the antidilutive adjustment provisions of the Convertible Notes, except in instances when such adjustments are deemed *de minimis*. The current conversion price of the Convertible Notes is $38.82, and the current conversion rate is 25.7582 for each $1,000 principal amount of the Convertible Notes.

Prior to December 1, 2018, we may redeem all or any part of the Convertible Notes if the volume weighted average price per share of our common stock is at least 120% of the conversion price of the Convertible Notes for at least 20 trading days during any 30 consecutive trading day period, at a redemption price equal to 100% of the principal amount of Convertible Notes to be redeemed, plus accrued and unpaid interest, provided that, as described above, the holders may elect to convert their Convertible Notes in lieu of the redemption and receive any make-whole premium due. On or after December 1, 2018, we may, at our option, redeem all or any part of the Convertible Notes at a redemption price equal to 100% of the principal amount of the Convertible Notes to be redeemed, plus accrued and unpaid interest.

Upon the occurrence of a fundamental change (as defined in the Convertible Notes Indenture), each holder of the Convertible Notes may require us to repurchase for cash all or any portion of such holders' Convertible Notes at a price equal to 100% of the principal amount of the repurchased Convertible Notes, plus accrued and unpaid interest thereon to, but excluding, the repurchase date and, if the fundamental change also constitutes a nonstock change of control (as defined in the Convertible Notes Indenture), the amount of any make-whole premium due. Holders may, at their option, also require us to repurchase all or any portion of such holders' Convertible Notes on December 1 of 2020, 2027, 2034, and 2041 at a price equal to 100% of the principal amount of the repurchased Convertible Notes, plus accrued and unpaid interest thereon to, but excluding, the repurchase date.

The Convertible Notes Indenture contains customary events of default, which includes, among other things, a default in the obligation of the Company to convert the Convertible Notes that continues for five business days.

See also Note 10, *Convertible Perpetual Preferred Stock.*

Other Notes Payable—

Our notes payable consist of the following (in millions):

	As of December 31,		Interest Rates
	2014	2013	
Sale/leaseback transactions involving real estate accounted for as financings	$ 28.0	$ 28.0	8.1% to 11.2%
Acquisition of an inpatient rehabilitation unit	2.9	4.3	7.8%
Construction of a new hospital	10.4	13.5	LIBOR + 2.5%; 2.7% as of December 31, 2014
Other	0.3	1.8	5.7% to 6.8%
Other notes payable	$ 41.6	$ 47.6	

Capital Lease Obligations—

We engage in a significant number of leasing transactions including real estate and other equipment utilized in operations. Leases meeting certain accounting criteria have been recorded as an asset and liability at the lower of fair value or the net present value of the aggregate future minimum lease payments at the inception of the lease. Interest rates used in computing the net present value of the lease payments generally ranged from 4% to 11% based on our incremental borrowing rate at the inception of the lease. Our leasing transactions include arrangements for vehicles with major finance companies and manufacturers who retain ownership in the equipment during the term of the lease and with a variety of both small and large real estate owners.

9. Self-Insured Risks:

We insure a substantial portion of our professional liability, general liability, and workers' compensation risks through a self-insured retention program ("SIR") underwritten by our consolidated wholly owned offshore captive insurance subsidiary, HCS, Ltd., which we fund via regularly scheduled premium payments. HCS is an independent insurance company licensed by the Cayman Island Monetary Authority. We use HCS to fund our first layer of insurance coverage up to $24.5 million for general and professional liability risks. Workers' compensation exposures are capped on a per claim basis. Risks in excess of specified limits per claim and in excess of our aggregate SIR amount are covered by unrelated commercial carriers.

The following table presents the changes in our self-insurance reserves for the years ended December 31, 2014, 2013, and 2012 (in millions):

	2014	2013	2012
Balance at beginning of period, gross	$ 140.3	$ 148.3	$ 153.3
Less: Reinsurance receivables	(32.6)	(29.4)	(34.4)
Balance at beginning of period, net	107.7	118.9	118.9
Increase for the provision of current year claims	34.7	34.4	33.8
Decrease for the provision of prior year claims	(3.5)	(5.9)	(6.4)
Decrease related to change in statistical confidence level	—	(6.7)	—
Expenses related to discontinued operations	(0.3)	(1.8)	(1.9)
Payments related to current year claims	(4.4)	(3.9)	(4.2)
Payments related to prior year claims	(25.9)	(27.3)	(21.3)
Acquisition of Encompass	0.3	—	—
Balance at end of period, net	108.6	107.7	118.9
Add: Reinsurance receivables	26.0	32.6	29.4
Balance at end of period, gross	$ 134.6	$ 140.3	$ 148.3

As of December 31, 2014 and 2013, $35.9 million and $42.1 million, respectively, of these reserves are included in *Other current liabilities* in our consolidated balance sheets.

Provisions for these risks are based primarily upon actuarially determined estimates. These reserves represent the unpaid portion of the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. The changes to the estimated ultimate loss amounts are included in current operating results.

Over the past few years, we have experienced volatility in our estimates of prior year claim reserves due primarily to favorable trends in claims and industry-wide loss development trends. Our efforts to improve patient safety and overall quality of care, as well as our efforts to reduce workplace injuries, have helped contain our ultimate claim costs. With the accumulation of this additional historical data and current favorable trends, when we analyzed our assumptions during our semi-annual review of our self-insurance reserves in the fourth quarter of 2013, we lowered the statistical confidence level used to determine our self-insurance reserves from 70% to 50%. This change, which reflects our current best estimate based on the trends we are experiencing in the resolution of claims, reduced our reserves included in continuing operations by $6.7 million in the fourth quarter of 2013.

The reserves for these self-insured risks cover approximately 1,100 and 1,150 individual claims at December 31, 2014 and 2013, respectively, and estimates for potential unreported claims. The time period required to resolve these claims can vary depending upon the jurisdiction, the nature, and the form of resolution of the claims. The estimation of the timing of payments beyond a year can vary significantly. Although considerable variability is inherent in reserve estimates, management believes the reserves for losses and loss expenses are adequate; however, there can be no assurance the ultimate liability will not exceed management's estimates.

10. Convertible Perpetual Preferred Stock:

On March 7, 2006, we completed the sale of 400,000 shares of our 6.50% Series A Convertible Perpetual Preferred Stock. The preferred stock has a liquidation preference of $1,000 per share of preferred stock, which is contingently subject to accretion. Holders of the preferred stock are entitled to receive, when and if declared by our board of directors, cash dividends at the rate of 6.50% per annum on the accreted liquidation preference per share, payable quarterly in arrears. Dividends on the

preferred stock are cumulative. Each holder of preferred stock has one vote for each share held by the holder on all matters voted upon by the holders of our common stock.

The preferred stock is convertible, at the option of the holder, at any time into shares of our common stock. We may at any time cause the shares of preferred stock to be automatically converted into shares of our common stock at the conversion rate then in effect if the closing sale price of our common stock for 20 trading days within a period of 30 consecutive trading days ending on the trading day before the date we give the notice of forced conversion exceeds 150% of the conversion price of the preferred stock. If we are subject to a fundamental change, as defined in the certificate of designation of the preferred stock, each holder of shares of preferred stock has the right, subject to certain limitations, to require us to purchase with cash any or all of its shares of preferred stock at a purchase price equal to 100% of the accreted liquidation preference, plus any accrued and unpaid dividends to the date of purchase. In addition, if holders of the preferred stock elect to convert shares of preferred stock in connection with certain fundamental changes, we will in certain circumstances increase the conversion rate for such shares of preferred stock. As redemption of the preferred stock is contingent upon the occurrence of a fundamental change, and since we do not deem a fundamental change probable of occurring, accretion of our *Convertible perpetual preferred stock* is not necessary.

The agreement underlying the preferred stock includes antidilutive protection that requires adjustments to the number of shares of common stock issuable upon conversion and the exercise price for common stock upon the occurrence of certain events, including payment of cash dividends on our common stock after a *de minimis* threshold. At issuance, the preferred stock had a conversion price of $30.50 per share, which was equal to an initial conversion rate of 32.7869 shares of common stock per share of preferred stock. The payment of dividends on our common stock has triggered and will continue to trigger, from time to time, the antidilutive adjustment provisions of the preferred stock, except when such adjustments are deemed *de minimis*. The current conversion price of the preferred stock is $29.70, and the current conversion rate is 33.6700 for each preferred share.

During the year ended December 31, 2012, we repurchased 46,645 shares of our preferred stock for total cash consideration of $46.5 million, including fees. In the fourth quarter of 2013, we exchanged $320.0 million in aggregate principal amount of newly issued 2.00% Convertible Senior Subordinated Notes due 2043 for 257,110 shares of our outstanding preferred stock. No common stock was issued as part of these exchange transactions. As of December 31, 2014 and 2013, 96,245 shares of our preferred stock remained outstanding. See Note 8, *Long-term Debt*.

The following is a summary of the activity related to our *Convertible perpetual preferred stock* from December 31, 2011 to December 31, 2014 (in millions, except share data):

	Number of Shares Outstanding	Amount
Balance as of December 31, 2011	400,000	$ 387.4
Repurchase of preferred stock	(46,645)	(45.2)
Balance as of December 31, 2012	353,355	342.2
Repurchase of preferred stock	(257,110)	(249.0)
Balance as of December 31, 2013 and 2014	96,245	93.2

The allocation of the consideration exchanged for repurchases of preferred stock is as follows (in millions):

	For the Year Ended December 31,	
	2013	2012
Carrying value of shares repurchased	$ 249.0	$ 45.2
Cumulative dividends included as part of repurchase price	2.2	0.5
Excess exchanged in transaction	71.6	0.8
	$ 322.8	$ 46.5

For 2013, the difference between the fair value of the consideration paid to the holders of the preferred stock, or $322.8 million (including fees), and the carrying value of the preferred stock in our balance sheet, or $249.0 million, resulted in a charge of $73.8 million to *Capital in excess of par value* that was treated like a dividend and subtracted from *Net income* to arrive at *Net income attributable to HealthSouth common shareholders* in our consolidated statement of operations. Of this amount, $2.2 million represents cumulative dividends through the date of the repurchase transactions.

For 2012, the difference between the fair value of the consideration paid to the holders of the preferred stock, or $46.5 million (including fees), and the carrying value of the preferred stock in our balance sheet, or $45.2 million, resulted in a charge of $1.3 million to *Capital in excess of par value* that was treated like a dividend and subtracted from *Net income* to arrive at *Net income attributable to HealthSouth common shareholders* in our consolidated statement of operations. Of this amount, $0.5 million represents cumulative dividends through the date of the repurchase transactions.

We declared $6.3 million, $21.0 million, and $23.9 million in dividends on our preferred stock in the years ended December 31, 2014, 2013, and 2012, respectively. As of December 31, 2014 and 2013, accrued dividends of $1.6 million were included in *Other current liabilities* on our consolidated balance sheets. These accrued dividends were paid in January 2015 and 2014, respectively.

11. Redeemable Noncontrolling Interests

The following is a summary of the activity related to our *Redeemable noncontrolling interests* (in millions):

	For the Year Ended December 31,		
	2014	2013	2012
Balance at beginning of period	$ 13.5	$ 7.2	$ 7.3
Acquisition of Encompass	64.5	—	—
Net income attributable to noncontrolling interests	6.6	5.8	3.8
Distributions	(8.5)	(4.9)	(3.9)
Contribution to joint venture	4.3	7.1	—
Change in fair value	4.3	(1.7)	—
Balance at end of period	$ 84.7	$ 13.5	$ 7.2

The following table reconciles the net income attributable to nonredeemable *Noncontrolling interests*, as recorded in the shareholders' equity section of the consolidated balance sheets, and the net income attributable to *Redeemable noncontrolling interests*, as recorded in the mezzanine section of the consolidated balance sheets, to the *Net income attributable to noncontrolling interests* presented on the consolidated statements of operations (in millions):

	For the Year Ended December 31,		
	2014	2013	2012
Net income attributable to nonredeemable noncontrolling interests	$ 53.1	$ 52.0	$ 47.1
Net income attributable to redeemable noncontrolling interests	6.6	5.8	3.8
Net income attributable to noncontrolling interests	$ 59.7	$ 57.8	$ 50.9

See also Note 2, *Business Combinations*.

12. Fair Value Measurements:

Our financial assets and liabilities that are measured at fair value on a recurring basis are as follows (in millions):

		Fair Value Measurements at Reporting Date Using			
As of December 31, 2014	**Fair Value**	**Quoted Prices in Active Markets for Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**	**Valuation Technique [1]**
Prepaid expenses and other current assets:					
Current portion of restricted marketable securities	$ 4.6	$ —	$ 4.6	$ —	M
Other long-term assets:					
Restricted marketable securities	45.9	—	45.9	—	M
As of December 31, 2013					
Prepaid expenses and other current assets:					
Current portion of restricted marketable securities	$ 4.7	$ —	$ 4.7	$ —	M
Other long-term assets:					
Restricted marketable securities	42.9	—	42.9	—	M

[1] The three valuation techniques are: market approach (M), cost approach (C), and income approach (I).

In addition to assets and liabilities recorded at fair value on a recurring basis, we are also required to record assets and liabilities at fair value on a nonrecurring basis. Generally, assets are recorded at fair value on a nonrecurring basis as a result of impairment charges or similar adjustments made to the carrying value of the applicable assets.

As a result of our consolidation of Fairlawn in 2014 and St. Vincent Rehabilitation Hospital in 2012 and the remeasurement of our previously held equity interest in each at fair value, we recorded a $27.2 million gain and a $4.9 million gain as part of *Other income* during the years ended December 31, 2014 and 2012, respectively. We determined the fair value of our previously held equity interest using the income approach. The income approach included the use of each hospital's projected operating results and cash flows discounted using a rate that reflects market participant assumptions for each hospital. The projected operating results used management's best estimates of economic and market conditions over the forecasted period including assumptions for pricing and volume, operating expenses, and capital expenditures. See Note 2, *Business Combinations*. During the year ended December 31, 2013, we did not record any material gains or losses related to our nonfinancial assets and liabilities that are recognized or disclosed at fair value in the financial statements on a nonrecurring basis as part of our continuing operations.

As discussed in Note 1, *Summary of Significant Accounting Policies*, "Fair Value Measurements," the carrying value equals fair value for our financial instruments that are not included in the table below and are classified as current in our consolidated balance sheets. The carrying amounts and estimated fair values for our other financial instruments are presented in the following table (in millions):

	As of December 31, 2014		As of December 31, 2013	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Long-term debt:				
Advances under revolving credit facility	$ 325.0	$ 325.0	$ 45.0	$ 45.0
Term loan facilities	450.0	450.0	—	—
7.25% Senior Notes due 2018	—	—	272.4	291.4
8.125% Senior Notes due 2020	287.0	302.5	286.6	319.4
7.75% Senior Notes due 2022	227.1	240.7	252.5	275.0
5.75% Senior Notes due 2024	456.2	471.4	275.0	273.6
2.00% Convertible Senior Subordinated Notes due 2043	258.0	358.4	249.5	339.7
Other notes payable	41.6	41.6	47.6	47.6
Financial commitments:				
Letters of credit	—	31.8	—	36.5

Fair values for our long-term debt and financial commitments are determined using inputs, including quoted prices in nonactive markets, that are observable either directly or indirectly, or *Level 2* inputs within the fair value hierarchy. See Note 1, *Summary of Significant Accounting Policies*, "Fair Value Measurements."

See also Note 11, *Redeemable Noncontrolling Interests*, and Note 15, *Assets and Liabilities in and Results of Discontinued Operations*.

13. Share-Based Payments:

The Company has awarded employee stock-based compensation in the form of stock options and restricted stock awards under the terms of share-based incentive plans designed to align employee and executive interests to those of its stockholders. All employee stock-based compensation awarded in 2014, 2013, and 2012 was issued under the Amended and Restated 2008 Equity Incentive Plan, a stockholder-approved plan that reserves and provides for the grant of up to nine million shares of common stock. This plan allows the grants of nonqualified stock options, incentive stock options, restricted stock, stock appreciation rights, performance shares, performance share units, dividend equivalents, restricted stock units ("RSUs"), and/or other stock-based awards.

See also Note 2, *Business Combinations*.

Stock Options—

Under our share-based incentive plans, officers and employees are given the right to purchase shares of HealthSouth common stock at a fixed grant price determined on the day the options are granted. The terms and conditions of the options, including exercise prices and the periods in which options are exercisable, are generally at the discretion of the compensation committee of our board of directors. However, no options are exercisable beyond ten years from the date of grant. Granted options vest over the awards' requisite service periods, which is generally three years.

The fair values of the options granted during the years ended December 31, 2014, 2013, and 2012 have been estimated at the grant date using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	For the Year Ended December 31,		
	2014	2013	2012
Expected volatility	40.3%	41.8%	42.8%
Risk-free interest rate	2.2%	1.4%	1.4%
Expected life (years)	7.2	7.2	7.0
Dividend yield	2.1%	0.0%	0.0%

The Black-Scholes option-pricing model was developed for use in estimating the fair value of traded options which have no vesting restrictions and are fully transferable. In addition, option-pricing models require the input of highly subjective assumptions, including the expected stock price volatility. We estimate our expected term through an analysis of actual, historical post-vesting exercise, cancellation, and expiration behavior by our employees and projected post-vesting activity of outstanding options. We calculate volatility based on the historical volatility of our common stock over the period commensurate with the expected life of the options. The risk-free interest rate is the implied daily yield currently available on U.S. Treasury issues with a remaining term closely approximating the expected term used as the input to the Black-Scholes option-pricing model. While our board of directors initiated quarterly cash dividends on our common stock in 2013 (see Note 17, *Earnings per Common Share*), we did not include a dividend payment as part of our pricing model in 2013 and 2012 because we had not historically paid dividends at the time of our option grants. In 2014, we estimated our dividend yield based on our annual dividend rate and our stock price on the dividend payment dates. We estimate forfeitures through an analysis of actual, historical pre-vesting option forfeiture activity. Under the Black-Scholes option-pricing model, the weighted-average fair value per share of employee stock options granted during the years ended December 31, 2014, 2013, and 2012 was $11.41, $10.96, and $9.57, respectively.

A summary of our stock option activity and related information is as follows:

	Shares (In Thousands)	Weighted-Average Exercise Price per Share	Weighted-Average Remaining Life (Years)	Aggregate Intrinsic Value (In Millions)
Outstanding, December 31, 2013	2,361	$ 20.82		
Granted	136	31.97		
Exercised	(290)	25.78		
Forfeitures	—	—		
Expirations	—	—		
Outstanding, December 31, 2014	2,207	20.85	4.3	$ 38.9
Exercisable, December 31, 2014	1,895	19.88	3.7	35.2

We recognized approximately $1.9 million, $2.1 million, and $2.0 million of compensation expense related to our stock options for the years ended December 31, 2014, 2013, and 2012, respectively. As of December 31, 2014, there was $1.8 million of unrecognized compensation cost related to unvested stock options. This cost is expected to be recognized over a weighted-average period of 20 months. The total intrinsic value of options exercised during the years ended December 31, 2014, 2013, and 2012 was $2.4 million, $1.9 million, and $0.1 million, respectively.

Restricted Stock—

The restricted stock awards granted in 2014, 2013, and 2012 included service-based awards, performance-based awards (that also included a service requirement), and market condition awards (that also included a service requirement). These awards generally vest over a three-year requisite service period. For awards with a service and/or performance

requirement, the fair value of the award is determined by the closing price of our common stock on the grant date. For awards with a market condition, the fair value of the awards is determined using a lattice model. Inputs into the model include the historical price volatility of our common stock, the historical volatility of the common stock of the companies in the defined peer group, and the risk free interest rate. Utilizing these inputs and potential future changes in stock prices, multiple trials are run to determine the fair value.

A summary of our issued restricted stock awards is as follows (share information in thousands):

	Shares	Weighted-Average Grant Date Fair Value
Nonvested shares at December 31, 2013	1,162	$ 22.89
Granted	861	23.94
Vested	(782)	23.35
Forfeited	(44)	23.72
Nonvested shares at December 31, 2014	1,197	23.31

The weighted-average grant date fair value of restricted stock granted during the years ended December 31, 2013 and 2012 was $23.55 and $19.30 per share, respectively. We recognized approximately $20.8 million, $21.6 million, and $21.2 million of compensation expense related to our restricted stock awards for the years ended December 31, 2014, 2013, and 2012, respectively. As of December 31, 2014, there was $16.4 million of unrecognized compensation expense related to unvested restricted stock. This cost is expected to be recognized over a weighted-average period of 19 months. The remaining unrecognized compensation expense for the performance-based awards may vary each reporting period based on changes in the expected achievement of performance measures. The total fair value of shares vested during the years ended December 31, 2014, 2013, and 2012 was $25.9 million, $15.7 million, and $34.0 million, respectively.

Nonemployee Stock-Based Compensation Plans—

During the years ended December 31, 2014, 2013, and 2012, we provided incentives to our nonemployee members of our board of directors through the issuance of RSUs out of our share-based incentive plans. RSUs are fully vested when awarded and receive dividend equivalents in the form of additional RSUs upon the payment of a cash dividend on our common stock. During the years ended December 31, 2014, 2013, and 2012, we issued 36,350, 51,180, and 42,903 RSUs, respectively, with a fair value of $33.02, $22.47, and $20.98, respectively, per unit. We recognized approximately $1.2 million, $1.2 million, and $0.9 million, respectively, of compensation expense upon their issuance in 2014, 2013, and 2012. There was no unrecognized compensation related to unvested shares as of December 31, 2014. During the years ended December 31, 2014 and 2013, we issued an additional 8,149 and 1,831, respectively, of RSUs as dividend equivalents. As of December 31, 2014, 353,466 RSUs were outstanding.

14. Employee Benefit Plans:

Substantially all HealthSouth employees are eligible to enroll in HealthSouth-sponsored healthcare plans, including coverage for medical and dental benefits. Our primary healthcare plans are national plans administered by third-party administrators. We are self-insured for these plans. During 2014, 2013, and 2012, costs associated with these plans, net of amounts paid by employees, approximated $85.2 million, $73.4 million, and $67.8 million, respectively.

The HealthSouth Retirement Investment Plan is a qualified 401(k) savings plan. The plan allows eligible employees to contribute up to 100% of their pay on a pre-tax basis into their individual retirement account in the plan subject to the normal maximum limits set annually by the Internal Revenue Service. HealthSouth's employer matching contribution is 50% of the first 6% of each participant's elective deferrals. All contributions to the plan are in the form of cash. Employees who are at least 21 years of age are eligible to participate in the plan. Employer contributions vest 100% after three years of service. Participants are always fully vested in their own contributions.

Employer contributions to the HealthSouth Retirement Investment Plan approximated $13.9 million, $13.2 million, and $13.2 million in 2014, 2013, and 2012, respectively. In 2014, 2013, and 2012, approximately $0.5 million, $0.5 million, and $0.8 million, respectively, from the plan's forfeiture account were used to fund the matching contributions in accordance with the terms of the plan.

Senior Management Bonus Program—

We maintain a Senior Management Bonus Program to reward senior management for performance based on a combination of corporate or regional goals and individual goals. The corporate and regional goals are approved on an annual basis by our board of directors as part of our routine budgeting and financial planning process. The individual goals, which are weighted according to importance, are determined between each participant and his or her immediate supervisor. The program applies to persons who join the Company in, or are promoted to, senior management positions. In 2015, we expect to pay approximately $7.9 million under the program for the year ended December 31, 2014. In February 2014 and 2013, we paid $11.5 million and $11.4 million, respectively, under the program for the years ended December 31, 2013 and 2012.

15. Assets and Liabilities in and Results of Discontinued Operations:

In connection with the 2007 sale of our surgery centers division (now known as Surgical Care Affiliates, or "SCA") to ASC Acquisition LLC, an affiliate of TPG Partners V, L.P. ("TPG"), a private investment partnership, we received an option, subject to terms and conditions set forth below, to purchase up to a 5% equity interest in SCA. The price of the option is equal to the original issuance price of the units subscribed for by TPG and certain other co-investors in connection with the acquisition plus a 15% premium, compounded annually. The option has a term of ten years and is exercisable upon certain liquidity events, including a public offering of SCA's shares of common stock that results in 30% or more of SCA's common stock being listed or traded on a national securities exchange. On November 4, 2013, SCA announced the closing of its initial public offering, which was not a qualifying liquidity event.

During the second quarter of 2014, we entered into an amendment to the option agreement that requires us to settle the option net of our exercise price. The addition of this new feature resulted in the option becoming a derivative that must be recorded as an asset or liability on our consolidated balance sheet and marked to market each period. As of December 31, 2014, the fair value of this option was $9.9 million and is included in *Other long-term assets* in our consolidated balance sheet. *Income from discontinued operations, net of tax* for the year ended December 31, 2014 included a $9.9 million net gain resulting from the initial recording of this option as a derivative and its fair value adjustments during 2014.

The fair value of the option and related adjustments were determined using a lattice model. Inputs into the model included the historical price volatility of SCA's common stock, the risk free interest rate, and probability factors for the timing of when the option will be exercisable, or *Level 3* inputs.

Income from discontinued operations, net of tax, in 2012 primarily resulted from gains associated with the sale of the real estate of Dallas Medical Center and an investment we had in a cancer treatment center that was part of our former diagnostic division.

16. Income Taxes:

The significant components of the *Provision for income tax expense* related to continuing operations are as follows (in millions):

	For the Year Ended December 31,		
	2014	2013	2012
Current:			
Federal	$ 2.5	$ 0.9	$ 0.7
State and other	10.8	5.4	5.2
Total current expense	13.3	6.3	5.9
Deferred:			
Federal	95.3	11.3	104.2
State and other	2.1	(4.9)	(1.5)
Total deferred expense	97.4	6.4	102.7
Total income tax expense related to continuing operations	$ 110.7	$ 12.7	$ 108.6

A reconciliation of differences between the federal income tax at statutory rates and our actual income tax expense on our income from continuing operations, which include federal, state, and other income taxes, is presented below:

	For the Year Ended December 31,		
	2014	2013	2012
Tax expense at statutory rate	35.0 %	35.0 %	35.0 %
Increase (decrease) in tax rate resulting from:			
State and other income taxes, net of federal tax benefit	4.3 %	4.0 %	3.7 %
Decrease in valuation allowance	(1.9)%	(2.3)%	(2.8)%
Settlement of tax claims	— %	(28.7)%	0.3 %
Noncontrolling interests	(5.1)%	(5.1)%	(5.1)%
Acquisition of additional equity interest in Fairlawn	(3.6)%	— %	— %
Other, net	(0.1)%	0.3 %	0.8 %
Income tax expense	28.6 %	3.2 %	31.9 %

The *Provision for income tax expense* in 2014 was less than the federal statutory rate primarily due to: (1) the impact of noncontrolling interests, (2) the nontaxable gain discussed in Note 2, *Business Combinations*, related to our acquisition of an additional 30% equity interest in Fairlawn, and (3) a decrease in our valuation allowance, as discussed below, offset by (4) state and other income tax expense. As a result of the Fairlawn transaction, we released the deferred tax liability associated with the outside tax basis of our investment in Fairlawn because we now possess sufficient ownership to allow for the historical outside tax basis difference to be resolved through a tax-free transaction in the future. See Note 1, *Summary of Significant Accounting Policies*, "Income Taxes," for a discussion of the allocation of income or loss related to pass-through entities, which is referred to as the impact of noncontrolling interests in the above table.

In April 2013, we entered into closing agreements with the IRS that settled federal income tax matters related to the previous restatement of our 2000 and 2001 financial statements, as well as certain other tax matters, through December 31, 2008. As a result of these closing agreements, we increased our deferred tax assets, primarily our federal net operating loss carryforward ("NOL"), and recorded a net federal income tax benefit of approximately $115 million in the second quarter of 2013. This federal income tax benefit primarily resulted from an approximate $283 million increase to our federal NOL on a gross basis.

The *Provision for income tax expense* in 2013 was less than the federal statutory rate primarily due to: (1) the IRS settlement discussed above, (2) the impact of noncontrolling interests, and (3) a decrease in our valuation allowance, as discussed below, offset by (4) state and other income tax expense. The *Provision for income tax expense* in 2012 is less than the federal statutory rate primarily due to: (1) the impact of noncontrolling interests and (2) a decrease in the valuation allowance, as discussed below, offset by (3) state and other income tax expense.

Deferred income taxes recognize the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and amounts used for income tax purposes and the impact of available NOLs. The significant components of HealthSouth's deferred tax assets and liabilities are presented in the following table (in millions):

	As of December 31,	
	2014	2013
Deferred income tax assets:		
Net operating loss	$ 301.3	$ 416.5
Property, net	40.7	44.3
Insurance reserve	25.6	28.5
Stock-based compensation	23.7	26.8
Allowance for doubtful accounts	18.0	15.3
Alternative minimum tax	10.5	11.1
Carrying value of partnerships	23.8	19.8
Other accruals	20.6	19.0
Tax credits	9.9	2.0
Other	1.6	1.2
Total deferred income tax assets	475.7	584.5
Less: Valuation allowance	(23.0)	(30.7)
Net deferred income tax assets	452.7	553.8
Deferred income tax liabilities:		
Intangibles	(97.5)	(29.2)
Convertible debt interest	(31.7)	(28.0)
Other	(5.7)	(3.3)
Total deferred income tax liabilities	(134.9)	(60.5)
Net deferred income tax assets	317.8	493.3
Less: Current deferred tax assets	188.4	139.0
Noncurrent deferred tax assets	$ 129.4	$ 354.3

At December 31, 2014, we had an unused federal NOL of $220.4 million (approximately $629.8 million on a gross basis) and state NOLs of $80.9 million. Such losses expire in various amounts at varying times through 2031. Our reported federal NOL as of December 31, 2014 excludes $8.6 million related to operating loss carryforwards resulting from excess tax benefits related to share-based awards, the tax benefits of which, when recognized, will be accounted for as a credit to additional paid-in-capital when they reduce taxes payable.

For the years ended December 31, 2014, 2013, and 2012, the net decreases in our valuation allowance were $7.7 million, $9.1 million, and $10.5 million, respectively. The decrease in our valuation allowance in 2014 related primarily to the expiration of state NOLs in certain jurisdictions, our current forecast of future earnings in each jurisdiction, and changes in certain state tax laws. The decrease in our valuation allowance in 2013 related primarily to our capital loss carryforwards, our then current forecast of future earnings in each jurisdiction, and changes in certain state tax laws. During the second quarter of 2013, we determined a valuation allowance related to our capital loss carryforwards was no longer required as sufficient positive evidence existed to substantiate their utilization. This evidence included our partial utilization of these assets as a result

of realizing capital gains in 2013 and the identification of sufficient taxable capital gain income within the available capital loss carryforward period. Substantially all of the decrease in the valuation allowance in 2012 related primarily to our determination it is more likely than not a substantial portion of our deferred tax assets will be realized in the future.

As of December 31, 2014, we have a remaining valuation allowance of $23.0 million. This valuation allowance remains recorded due to uncertainties regarding our ability to utilize a portion of our state NOLs before they expire. The amount of the valuation allowance has been determined for each tax jurisdiction based on the weight of all available evidence including management's estimates of taxable income for each jurisdiction in which we operate over the periods in which the related deferred tax assets will be recoverable. It is possible we may be required to increase or decrease our valuation allowance at some future time if our forecast of future earnings varies from actual results on a consolidated basis or in the applicable state tax jurisdictions, or if the timing of future tax deductions differs from our expectations.

As of January 1, 2012, total remaining gross unrecognized tax benefits were $6.0 million, all of which would have affected our effective tax rate if recognized. Total accrued interest expense related to unrecognized tax benefits was $0.1 million as of January 1, 2012. The amount of unrecognized tax benefits changed during 2012 primarily based on our then ongoing discussions with taxing authorities as part of our continued pursuit of the maximization of our tax benefits, primarily related to our federal NOL. Total remaining gross unrecognized tax benefits were $78.0 million as of December 31, 2012, $76.0 million of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits changed during 2013 primarily due to the April 2013 IRS settlement discussed above. Total remaining gross unrecognized tax benefits were $1.1 million as of December 31, 2013, $0.4 million of which would have affected our effective tax rate if recognized. The amount of unrecognized tax benefits did not change significantly during 2014. Total remaining gross unrecognized tax benefits were $0.9 million as of December 31, 2014, all of which would affect our effective tax rate if recognized.

A reconciliation of the beginning and ending liability for unrecognized tax benefits is as follows (in millions):

	Gross Unrecognized Income Tax Benefits	Accrued Interest and Penalties
January 1, 2012	$ 6.0	$ 0.1
Gross amount of increases in unrecognized tax benefits related to prior periods	75.8	—
Gross amount of decreases in unrecognized tax benefits related to prior periods	(2.5)	—
Decreases in unrecognized tax benefits relating to settlements with taxing authorities	(0.9)	—
Reductions to unrecognized tax benefits as a result of a lapse of the applicable statute of limitations	(0.4)	(0.1)
December 31, 2012	78.0	—
Gross amount of increases in unrecognized tax benefits related to prior periods	46.7	0.3
Gross amount of decreases in unrecognized tax benefits related to prior periods	(1.9)	—
Decreases in unrecognized tax benefits relating to settlements with taxing authorities	(121.7)	—
December 31, 2013	1.1	0.3
Gross amount of increases in unrecognized tax benefits related to prior periods	0.7	0.1
Gross amount of decreases in unrecognized tax benefits related to prior periods	(0.9)	(0.4)
December 31, 2014	$ 0.9	$ —

Our continuing practice is to recognize interest and penalties related to income tax matters in income tax expense. Interest recorded as part of our income tax provision during 2014, 2013, and 2012 was not material. Accrued interest income related to income taxes as of December 31, 2014 and 2013 was not material.

In December 2014, we signed an agreement with the IRS to begin participating in their Compliance Assurance Process, a program in which we and the IRS endeavor to agree on the treatment of significant tax positions prior to the filing of

our federal income tax return. As a result of this agreement, the IRS is currently surveying our 2013 federal income tax return and will examine our 2014 return when it is filed. The IRS has previously surveyed our 2012 and 2011 federal income tax returns. We have settled federal income tax examinations with the IRS for all tax years through 2010. Our state income tax returns are also periodically examined by various regulatory taxing authorities. We are currently under audit by two states for tax years ranging from 2007 through 2011.

For the tax years that remain open under the applicable statutes of limitations, amounts related to these unrecognized tax benefits have been considered by management in its estimate of our potential net recovery of prior years' income taxes. We do not expect a material change in our unrecognized tax benefits within the next 12 months due to the closing of the applicable statutes of limitation.

17. Earnings per Common Share:

The following table sets forth the computation of basic and diluted earnings per common share (in millions, except per share amounts):

	For the Year Ended December 31,		
	2014	2013	2012
Basic:			
Numerator:			
Income from continuing operations	$ 276.2	$ 382.5	$ 231.4
Less: Net income attributable to noncontrolling interests included in continuing operations	(59.7)	(57.8)	(50.9)
Less: Income allocated to participating securities	(2.3)	(3.4)	(2.2)
Less: Convertible perpetual preferred stock dividends	(6.3)	(21.0)	(23.9)
Less: Repurchase of convertible perpetual preferred stock	—	(71.6)	(0.8)
Income from continuing operations attributable to HealthSouth common shareholders	207.9	228.7	153.6
Income (loss) from discontinued operations, net of tax, attributable to HealthSouth common shareholders	5.5	(1.1)	4.5
Less: Income from discontinued operations allocated to participating securities	(0.1)	—	(0.1)
Net income attributable to HealthSouth common shareholders	$ 213.3	$ 227.6	$ 158.0
Denominator:			
Basic weighted average common shares outstanding	86.8	88.1	94.6
Basic earnings per share attributable to HealthSouth common shareholders:			
Continuing operations	$ 2.40	$ 2.59	$ 1.62
Discontinued operations	0.06	(0.01)	0.05
Net income	$ 2.46	$ 2.58	$ 1.67
Diluted:			
Numerator:			
Income from continuing operations	$ 276.2	$ 382.5	$ 231.4
Less: Net income attributable to noncontrolling interests included in continuing operations	(59.7)	(57.8)	(50.9)
Add: Interest on convertible debt, net of tax	9.0	1.0	—
Income from continuing operations attributable to HealthSouth common shareholders	225.5	325.7	180.5
Income (loss) from discontinued operations, net of tax, attributable to HealthSouth common shareholders	5.5	(1.1)	4.5
Net income attributable to HealthSouth common shareholders	$ 231.0	$ 324.6	$ 185.0
Denominator:			
Diluted weighted average common shares outstanding	100.7	102.1	108.1
Diluted earnings per share attributable to HealthSouth common shareholders:			
Continuing operations	$ 2.24	$ 2.59	$ 1.62
Discontinued operations	0.05	(0.01)	0.05
Net income	$ 2.29	$ 2.58	$ 1.67

The following table sets forth the reconciliation between basic weighted average common shares outstanding and diluted weighted average common shares outstanding (in millions):

	For the Year Ended December 31,		
	2014	2013	2012
Basic weighted average common shares outstanding	86.8	88.1	94.6
Convertible perpetual preferred stock	3.2	10.5	12.0
Convertible senior subordinated notes	8.2	1.0	—
Restricted stock awards, dilutive stock options, and restricted stock units	2.5	2.5	1.5
Diluted weighted average common shares outstanding	100.7	102.1	108.1

For the year ended December 31, 2013, adding back amounts related to the repurchase of our preferred stock to our *Income from continuing operations attributable to HealthSouth common shareholders* causes a per share increase when calculating diluted earnings per common share resulting in an antidilutive per share amount. See Note 10, *Convertible Perpetual Preferred Stock*. For the year ended December 31, 2012, adding back the dividends on our preferred stock to our *Income from continuing operations attributable to HealthSouth common shareholders* causes a per share increase when calculating diluted earnings per common share resulting in an antidilutive per share amount. Therefore, basic and diluted earnings per common share are the same for the years ended December 31, 2013 and 2012.

Options to purchase approximately 0.1 million shares of common stock were outstanding as of December 31, 2014 and 2013 but were not included in the computation of diluted weighted-average shares because to do so would have been antidilutive.

In February 2013, our board of directors approved an increase in our existing common stock repurchase authorization from $125 million (authorized in October 2011) to $350 million. During the first quarter of 2013, we completed a tender offer for our common stock. As a result of the tender offer, we purchased 9.1 million shares at a price of $25.50 per share for a total cost of $234.1 million, including fees and expenses relating to the tender offer. The remaining repurchase authorization expired at the end of the tender offer.

In October 2013, our board of directors authorized the repurchase of up to $200 million of our common stock. In February 2014, our board of directors approved an increase in this common stock repurchase authorization from $200 million to $250 million. The repurchase authorization does not require the repurchase of a specific number of shares, has an indefinite term, and is subject to termination at any time by our board of directors. During 2014, we repurchased 1.3 million shares of our common stock in the open market for $43.1 million.

In July 2013, our board of directors approved the initiation of a quarterly cash dividend of $0.18 per share on our common stock. The first quarterly dividend was declared in July 2013 and paid in October 2013. This $0.18 per share cash dividend on our common stock was declared and paid each quarter through July 2014. In July 2014, our board of directors approved an increase in the quarterly cash dividend on our common stock and declared a dividend of $0.21 per share. The cash dividend of $0.21 per common share was declared in July 2014 and October 2014 and paid in October 2014 and January 2015. As of December 31, 2014 and 2013, accrued common stock dividends of $18.6 million and $15.8 million were included in *Other current liabilities* in our consolidated balance sheet. Future dividend payments are subject to declaration by our board of directors.

In January 2004, we repaid our then-outstanding 3.25% Convertible Debentures using the net proceeds of a loan arranged by Credit Suisse First Boston. In connection with this transaction, we issued ten million warrants with an expiration date of January 16, 2014 to the lender to purchase shares of our common stock. The agreement underlying these warrants included antidilutive protection that required adjustments to the number of shares of common stock purchasable upon exercise and the exercise price for common stock upon the occurrence of certain events. Following our one-for-five reverse stock split in October 2006, the warrants were exercisable for two million shares of our common stock at an exercise price of $32.50. This antidilution protection also provided for adjustment upon payment of cash dividends on our common stock after a *de minimis* threshold. The payment in January 2014 of an $0.18 per share dividend on our common stock triggered the antidilutive adjustment for these warrants. When these warrants expired in January 2014, the resulting exercise price of each warrant was

$32.16, and the resulting exercise rate was 0.2021 for each warrant. The warrants were not assumed exercised for dilutive shares outstanding for the year ended December 31, 2012 because they were antidilutive in that period.

The following table summarizes information relating to these warrants and their activity during 2013 and through their expiration date (number of warrants in millions):

	Number of Warrants	Weighted Average Exercise Price
Common stock warrants outstanding as of December 31, 2012	10.0	$ 32.50
Cashless exercise	(4.8)	32.50
Cash exercise	(2.3)	32.50
Common stock warrants outstanding as of December 31, 2013	2.9	32.50
Cashless exercise	(1.8)	32.16
Cash exercise	(1.0)	32.16
Expired	(0.1)	32.16
Common stock warrants outstanding as of January 16, 2014	—	

The above exercises resulted in the issuance of 0.5 million and 0.2 million shares of common stock in 2013 and 2014, respectively. Cash exercises resulted in gross proceeds of $15.3 million and $6.3 million during 2013 and 2014, respectively.

On September 30, 2009, we issued 5.0 million shares of common stock and 8.2 million common stock warrants in full satisfaction of our obligation to do so under the January 2007 comprehensive settlement of the consolidated securities action brought against us by our stockholders and bondholders. Each warrant has a term of approximately seven years from the date of issuance and an exercise price of $41.40 per share. The warrants were not assumed exercised for dilutive shares outstanding because they were antidilutive in the periods presented.

See also Note 8, *Long-term Debt*, and Note 10, *Convertible Perpetual Preferred Stock*.

18. Contingencies and Other Commitments:

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims, and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. The resolution of any such lawsuits, claims, or legal and regulatory proceedings could materially and adversely affect our financial position, results of operations, and cash flows in a given period.

Derivative Litigation—

All lawsuits purporting to be derivative complaints on our behalf filed in the Circuit Court of Jefferson County, Alabama since 2002 have been dismissed or consolidated with the first-filed action captioned *Tucker v. Scrushy* and filed August 28, 2002. Derivative lawsuits in other jurisdictions have been stayed as well. The *Tucker* complaint asserted claims on our behalf against, among others, a number of our former officers and directors and Ernst & Young LLP, our former auditor. When originally filed, the primary allegations in the *Tucker* case involved self-dealing by Richard M. Scrushy, our former chairman and chief executive officer, and other insiders through transactions with various entities allegedly controlled by Mr. Scrushy. The complaint was amended four times to add additional defendants and include claims of accounting fraud, improper Medicare billing practices, and additional self-dealing transactions.

The claims against all defendants in the *Tucker* case have been settled or otherwise resolved. The *Tucker* derivative litigation against Ernst & Young is discussed in more detail below. In 2013, we and the derivative stockholder plaintiffs resolved all claims against the remaining individual defendants. These resolutions included the entry of final judgments against five former officers and resulted in the collection of approximately $5 million during 2013. As a reminder, the 2009 final judgment against Mr. Scrushy found him guilty of fraud and breach of fiduciary duties and ordered him to pay $2.9 billion in damages to us. Our collection efforts against Mr. Scrushy are ongoing.

For the years ended December 31, 2014, 2013, and 2012, we recorded net gains of $1.7 million, $9.3 million, and $3.5 million, respectively, in *Government, class action, and related settlements* in our consolidated statements of operations in connection with our receipt of cash distributions from Mr. Scrushy and the other former officers, after reimbursement of reasonable out-of-pocket expenses incurred by HealthSouth and the attorneys for the derivative stockholder plaintiffs and after recording a liability for the federal securities plaintiffs' 25% apportionment of the net recovery as required in the January 2007 comprehensive settlement of the consolidated securities action brought against us by our stockholders and bondholders. We are obligated to pay 35% of the recoveries from Mr. Scrushy and the other former officers along with reasonable out-of-pocket expenses to the attorneys for the derivative stockholder plaintiffs. In connection with those obligations, during 2014, 2013, and 2012, $0.7 million, $3.3 million, and $1.4 million, respectively, of the amounts previously collected were distributed to attorneys for the derivative stockholder plaintiffs. We recorded these cash distributions as part of *Professional fees—accounting, tax, and legal* in our consolidated statements of operations for those years.

We had previously recorded an estimated liability for the federal securities plaintiffs' claim for the 25% apportionment of any net recovery from the defendants in the derivative litigation. In September 2013, these plaintiffs filed a request with the federal court overseeing the related settlement to approve an agreement reached on how to calculate this apportionment obligation. As a result of this filing with the court, we recorded a noncash reduction to the liability originally recorded in 2006 for this obligation during 2013 as part of *Government, class action, and related settlements* in our consolidated statements of operations.

Litigation By and Against Former Independent Auditor—

In March 2003, claims on behalf of HealthSouth were brought in the *Tucker* derivative litigation against Ernst & Young, alleging that from 1996 through 2002, when Ernst & Young served as our independent auditor, Ernst & Young acted recklessly and with gross negligence in performing its duties, and specifically that Ernst & Young failed to perform reviews and audits of our financial statements with due professional care as required by law and by its contractual agreements with us. The claims further allege Ernst & Young either knew of or, in the exercise of due care, should have discovered and investigated the fraudulent and improper accounting practices being directed by certain officers and employees, and should have reported them to our board of directors and the audit committee. The claims sought compensatory and punitive damages, disgorgement of fees received from us by Ernst & Young, and attorneys' fees and costs.

On March 18, 2005, Ernst & Young filed a lawsuit captioned *Ernst & Young LLP v. HealthSouth Corp.* in the Circuit Court of Jefferson County, Alabama. The complaint alleged we provided Ernst & Young with fraudulent management representation letters, financial statements, invoices, bank reconciliations, and journal entries in an effort to conceal accounting fraud. Ernst & Young claimed that as a result of our actions, Ernst & Young's reputation had been injured and it incurred damages, expenses, and legal fees. On April 1, 2005, we answered Ernst & Young's claims and asserted counterclaims related or identical to those asserted in the *Tucker* action. Upon Ernst & Young's motion, the Alabama state court referred Ernst & Young's claims and our counterclaims to arbitration pursuant to a clause in the engagement agreements between HealthSouth and Ernst & Young. In August 2006, we and the derivative plaintiffs agreed to jointly prosecute the claims against Ernst & Young in arbitration.

The trial phase of the arbitration process began on July 12, 2010 before a three-person arbitration panel selected under rules of the American Arbitration Association (the "AAA"). On December 18, 2012, the AAA panel granted Ernst & Young's motion to dismiss our claims on the grounds that HealthSouth was not permitted to pursue its claims since certain of its former officers and employees committed fraudulent acts. The panel also denied and dismissed Ernst & Young's claims against us. On December 18, 2012, we, together with the stockholder derivative plaintiffs, filed a notice of appeal of the panel's decision in the Circuit Court of Jefferson County, Alabama. On December 28, 2012, we filed a motion to vacate the decision. We asserted that the panel's decision was contrary to the Federal Arbitration Act and the duties of a public accounting firm to its corporate clients, and that the arbitrators exceeded their authority by entering an award contrary to Alabama law. On April 25, 2013, the court denied our motion to vacate. On June 4, 2013, we filed a notice of appeal to the Supreme Court of Alabama seeking review of the circuit court's denial of our motion to vacate the arbitration panel's decision. On June 13, 2014, the Supreme Court of Alabama affirmed the decision by the circuit court. On June 27, 2014, we filed an application for rehearing with the Supreme Court of Alabama. On August 22, 2014, the Supreme Court of Alabama denied our application, and as a result, we consider this litigation matter concluded.

General Medicine Action—

On August 16, 2004, General Medicine, P.C. filed a lawsuit against us captioned *General Medicine, P.C. v. HealthSouth Corp.* seeking the recovery of allegedly fraudulent transfers involving assets of Horizon/CMS Healthcare Corporation, a former subsidiary of HealthSouth. The lawsuit is pending in the Circuit Court of Jefferson County, Alabama (the "Alabama Action").

General Medicine's underlying claim against Horizon/CMS originates from a services contract entered into in 1995 between General Medicine and Horizon/CMS whereby General Medicine agreed to provide medical director services to skilled nursing facilities owned by Horizon/CMS for a term of three years. Horizon/CMS terminated the agreement for cause six months after it was executed, and General Medicine then initiated a lawsuit against Horizon/CMS in the United States District Court for the Eastern District of Michigan in 1996 (the "Michigan Action"). General Medicine's complaint in the Michigan Action alleged that Horizon/CMS breached the services contract by wrongfully terminating General Medicine. We acquired Horizon/CMS in 1997 and sold it to Meadowbrook Healthcare, Inc. in 2001 pursuant to a stock purchase agreement. In 2004, Meadowbrook, without the knowledge of HealthSouth, consented to the entry of a final judgment in the Michigan Action in favor of General Medicine against Horizon/CMS for the alleged wrongful termination of the contract with General Medicine in the amount of $376 million, plus interest from the date of the judgment until paid at the rate of 10% per annum (the "Consent Judgment"). The $376 million damages figure was unilaterally selected by General Medicine and was not tested or opposed by Meadowbrook. Additionally, the settlement agreement (the "Settlement") used as the basis for the Consent Judgment provided that Meadowbrook would pay only $300,000 to General Medicine to settle the Michigan Action and that General Medicine would seek to recover the remaining balance of the Consent Judgment solely from us. We were not a party to the Michigan Action, the Settlement negotiated by Meadowbrook, or the Consent Judgment.

The complaint filed by General Medicine against us in the Alabama Action alleges that while Horizon/CMS was our wholly owned subsidiary, General Medicine was an existing creditor of Horizon/CMS by virtue of the breach of contract claim underlying the Settlement. The complaint also alleges we caused Horizon/CMS to transfer its assets to us for less than a reasonably equivalent value or, in the alternative, with the actual intent to defraud creditors of Horizon/CMS, including General Medicine, in violation of the Alabama Uniform Fraudulent Transfer Act. General Medicine further alleges in its amended complaint that we are liable for the Consent Judgment despite not being a party to it because as Horizon/CMS's parent we failed to observe corporate formalities in our operation and ownership of Horizon/CMS, misused our control of Horizon/CMS, stripped assets from Horizon/CMS, and engaged in other conduct which amounted to a fraud on Horizon/CMS's creditors. General Medicine has requested relief including recovery of the unpaid amount of the Consent Judgment, the avoidance of the subject transfers of assets, attachment of the assets transferred to us, appointment of a receiver over the transferred properties, and a monetary judgment for the value of properties transferred.

We have denied liability to General Medicine and asserted defenses and a counterclaim against General Medicine that the Consent Judgment is the product of collusion by General Medicine and Meadowbrook. Consequently, we assert that the Consent Judgment is not evidence of a legitimate debt owed by Horizon/CMS to General Medicine that is collectible from HealthSouth under any theory of liability.

In 2008, after we obtained discovery concerning the circumstances that led to the entry of the Consent Judgment, we filed a motion in the Michigan Action asking the court to set aside the Consent Judgment on grounds that it was the product of fraud on the court and collusion by the parties. On May 21, 2009, the court granted our motion to set aside the Consent Judgment on grounds that it was the product of fraud on the court. On March 9, 2010, General Medicine filed an appeal of the court's decision to the Sixth Circuit Court of Appeals. The parties agreed to a voluntary stay of the Alabama Action pending the outcome of General Medicine's appeal to the Sixth Circuit Court of Appeals. On April 10, 2012, the Sixth Circuit Court of Appeals reversed the lower court's ruling and reinstated the Consent Judgment. Due to the conclusion of the appeal in the Michigan Action, General Medicine requested reactivation of the Alabama Action in the Circuit Court of Jefferson County, Alabama. On January 10, 2013, we filed a motion for partial summary judgment in the Alabama Action seeking a declaration that the Consent Judgment obtained by General Medicine is not enforceable against us because, among other reasons, it was the result of collusion. On February 27, 2013, the court denied our motion. The court also indicated it concurred with the Sixth Circuit Court of Appeals that the Consent Judgment did nothing more than establish Horizon/CMS's liability to General Medicine and did not establish the amount of General Medicine's damages claim against Horizon/CMS or the merits of General Medicine's separate fraudulent conveyance claims against HealthSouth.

On January 9, 2014 and on February 18, 2014, the court in the Alabama Action entered rulings based on General Medicine's stipulation that it would not rely on the Consent Judgment to prove the amount of its damages claim against Horizon/CMS, which rulings together provided that the $376 million damages figure contained in the Consent Judgment is not admissible at trial and that the issue of collusion with respect to the amount of the Consent Judgment is now moot. Instead of relying on the Consent Judgment to prove damages against Horizon/CMS, General Medicine will be required to prove the amount of any damages it has against Horizon/CMS. General Medicine did, however, indicate it would rely on the Consent Judgment to prove its status as a creditor of Horizon/CMS and that Horizon/CMS is indebted to General Medicine for breaching the 1995 services contract. On March 31, 2014, General Medicine filed a motion seeking partial summary judgment and requesting dismissal of our defenses and counterclaim which allege the Consent Judgment was the product of collusion. In opposition to the motion, we argued the Consent Judgment is collusive in its entirety, not just with respect to the $376 million damages figure, and there has never been a valid adjudication that Horizon/CMS breached its 1995 services contract with General Medicine or that Horizon/CMS is indebted to General Medicine for any amount. On July 15, 2014, the court issued an order denying General Medicine's motion for partial summary judgment.

On May 3, 2014, the Consent Judgment expired under applicable Michigan law without renewal by General Medicine. Based on the expiration, on July 23, 2014, we filed a motion for summary judgment requesting dismissal of General Medicine's lawsuit against us on grounds that General Medicine is no longer a "creditor" of Horizon/CMS, which is an essential element of the fraudulent transfer and alter ego claims against us, and that General Medicine's lawsuit against us is now moot. On August 13, 2014, the court denied our motion for summary judgment.

The trial began on September 15, 2014. On September 16, 2014, the court issued a provisional ruling precluding us from offering any evidence at trial that the Consent Judgment was the product of collusion by General Medicine and Meadowbrook, unless General Medicine opens the door by introducing evidence of the $376 million amount of the Consent Judgment. On September 18, 2014, the court granted General Medicine's motion for a mistrial based on certain statements made during opening statements. The Alabama Action has been reset for trial beginning on March 9, 2015.

We intend to vigorously defend ourselves against General Medicine's claims. Based on the stage of litigation, review of the current facts and circumstances as we understand them, the nature of the underlying claim, the results of the proceedings to date, and the nature and scope of the defense we continue to mount, we do not believe an adverse judgment or settlement is probable in this matter, and it is also not possible to estimate the amount of loss, if any, or range of possible loss that might result from an adverse judgment or settlement of this case.

Other Litigation—

We have been named as a defendant in a lawsuit filed March 28, 2003 by several individual stockholders in the Circuit Court of Jefferson County, Alabama, captioned *Nichols v. HealthSouth Corp.* The plaintiffs allege that we, some of our former officers, and our former investment bank engaged in a scheme to overstate and misrepresent our earnings and financial position. The plaintiffs are seeking compensatory and punitive damages. This case was consolidated with the *Tucker* case for discovery and other pretrial purposes and was stayed in the Circuit Court on August 8, 2005. The plaintiffs filed an amended complaint on November 9, 2010 to which we responded with a motion to dismiss filed on December 22, 2010. During a hearing on February 24, 2012, plaintiffs' counsel indicated his intent to dismiss certain claims against us. Instead, on March 9, 2012, the plaintiffs amended their complaint to include additional securities fraud claims against HealthSouth and add several former officers to the lawsuit. On September 12, 2012, the plaintiffs further amended their complaint to request certification as a class action. One of those named officers has repeatedly attempted to remove the case to federal district court, most recently on December 11, 2012. We filed our latest motion to remand the case back to state court on January 10, 2013. On September 27, 2013, the federal court remanded the case back to state court. On November 25, 2014, the plaintiffs filed another amended complaint to assert new allegations relating to the time period of 1997 to 2002. On December 10, 2014, we filed a motion to dismiss on the grounds the plaintiffs lack standing because their claims are derivative in nature, and the claims are time-barred by the statute of limitations. A hearing on our motion has not yet been set.

We intend to vigorously defend ourselves in this case. Based on the stage of litigation, review of the current facts and circumstances as we understand them, the nature of the underlying claim, the results of the proceedings to date, and the nature and scope of the defense we continue to mount, we do not believe an adverse judgment or settlement is probable in this matter, and it is also not possible to estimate the amount of loss, if any, or range of possible loss that might result from an adverse judgment or settlement of this case.

Governmental Inquiries and Investigations—

On June 24, 2011, we received a document subpoena addressed to HealthSouth Hospital of Houston, a long-term acute care hospital ("LTCH") we closed in August 2011, and issued from the Dallas, Texas office of the HHS-OIG. The subpoena stated it was in connection with an investigation of possible false or otherwise improper claims submitted to Medicare and Medicaid and requested documents and materials relating to patient admissions, length of stay, and discharge matters at this closed LTCH. We furnished the documents requested and have heard nothing from HHS-OIG since December 2012.

On March 4, 2013, we received document subpoenas from an office of the HHS-OIG addressed to four of our hospitals. Those subpoenas also requested complete copies of medical records for 100 patients treated at each of those hospitals between September 2008 and June 2012. The investigation is being conducted by the United States Department of Justice (the "DOJ"). On April 24, 2014, we received document subpoenas relating to an additional seven of our hospitals. Those subpoenas reference substantially similar investigation subject matter as the original subpoenas and request materials from the period January 2008 through December 2013. Two of the four hospitals addressed in the original set of subpoenas have received supplemental subpoenas to cover this new time period. The most recent subpoenas do not include requests for specific patient files. However, the DOJ recently requested the medical records of an additional 70 patients, and we have agreed to voluntarily provide these records.

All of the subpoenas are in connection with an investigation of alleged improper or fraudulent claims submitted to Medicare and Medicaid and request documents and materials relating to practices, procedures, protocols and policies, of certain pre- and post-admissions activities at these hospitals including, among other things, marketing functions, pre-admission screening, post-admission physician evaluations, patient assessment instruments, individualized patient plans of care, and compliance with the Medicare 60% rule. Under the Medicare rule commonly referred to as the "60% rule," an inpatient rehabilitation hospital must treat 60% or more of its patients from at least one of a specified list of medical conditions in order to be reimbursed at the inpatient rehabilitation hospital payment rates, rather than at the lower acute care hospital payment rates.

We are cooperating fully with the DOJ in connection with the subpoenas and are currently unable to predict the timing or outcome of the related investigations.

Other Matters—

The False Claims Act, 18 U.S.C. § 287, allows private citizens, called "relators," to institute civil proceedings alleging violations of the False Claims Act. These *qui tam* cases are sealed by the court at the time of filing. Prior to the release of the seal by the presiding court, the only parties typically privy to the information contained in the complaint are the relator, the federal government, and the court. It is possible that *qui tam* lawsuits have been filed against us and that those suits remain under seal or that we are unaware of such filings or prevented by existing law or court order from discussing or disclosing the filing of such suits. We may be subject to liability under one or more undisclosed *qui tam* cases brought pursuant to the False Claims Act.

It is our obligation as a participant in Medicare and other federal healthcare programs to routinely conduct audits and reviews of the accuracy of our billing systems and other regulatory compliance matters. As a result of these reviews, we have made, and will continue to make, disclosures to the HHS-OIG and CMS relating to amounts we suspect represent over-payments from these programs, whether due to inaccurate billing or otherwise. Some of these disclosures have resulted in, or may result in, HealthSouth refunding amounts to Medicare or other federal healthcare programs.

Other Commitments—

We are a party to service and other contracts in connection with conducting our business. Minimum amounts due under these agreements are $32.5 million in 2015, $23.1 million in 2016, $11.2 million in 2017, $10.6 million in 2018, $10.0 million in 2019, and $15.9 million thereafter. These contracts primarily relate to software licensing and support.

19. Quarterly Data (Unaudited):

	2014				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 591.2	$ 604.4	$ 596.9	$ 613.4	$ 2,405.9
Operating earnings [a]	105.8	115.4	100.7	96.5	418.4
Provision for income tax expense	32.8	36.5	22.1	19.3	110.7
Income from continuing operations	61.6	94.1	65.7	54.8	276.2
(Loss) income from discontinued operations, net of tax	(0.1)	3.8	(0.9)	2.7	5.5
Net income	61.5	97.9	64.8	57.5	281.7
Less: Net income attributable to noncontrolling interests	(14.8)	(14.8)	(14.7)	(15.4)	(59.7)
Net income attributable to HealthSouth	$ 46.7	$ 83.1	$ 50.1	$ 42.1	$ 222.0
Earnings per common share:					
Basic earnings per share attributable to HealthSouth common shareholders: [b]					
Continuing operations	$ 0.51	$ 0.89	$ 0.56	$ 0.43	$ 2.40
Discontinued operations	—	0.04	(0.01)	0.03	0.06
Net income	$ 0.51	$ 0.93	$ 0.55	$ 0.46	$ 2.46
Diluted earnings per share attributable to HealthSouth common shareholders: [b]					
Continuing operations	$ 0.48	$ 0.81	$ 0.53	$ 0.41	$ 2.24
Discontinued operations	—	0.04	(0.01)	0.03	0.05
Net income	$ 0.48	$ 0.85	$ 0.52	$ 0.44	$ 2.29

(a) We define operating earnings as income from continuing operations attributable to HealthSouth before (1) loss on early extinguishment of debt; (2) interest expense and amortization of debt discounts and fees; (3) other income; and (4) income tax expense.

(b) Per share amounts may not sum due to the weighted average common shares outstanding during each quarter compared to the weighted average common shares outstanding during the entire year.

	2013				
	First	Second	Third	Fourth	Total
	(In Millions, Except Per Share Data)				
Net operating revenues	$ 572.6	$ 564.5	$ 564.0	$ 572.1	$ 2,273.2
Operating earnings [a]	108.7	101.1	119.0	106.9	435.7
Provision for income tax expense (benefit)	33.5	(86.5)	35.2	30.5	12.7
Income from continuing operations	66.3	178.9	73.2	64.1	382.5
(Loss) income from discontinued operations, net of tax	(0.4)	0.1	(0.9)	0.1	(1.1)
Net income	65.9	179.0	72.3	64.2	381.4
Less: Net income attributable to noncontrolling interests	(14.6)	(13.8)	(14.1)	(15.3)	(57.8)
Net income attributable to HealthSouth	$ 51.3	$ 165.2	$ 58.2	$ 48.9	$ 323.6
Earnings (loss) per common share:					
Basic earnings (loss) per share attributable to HealthSouth common shareholders: [b]					
Continuing operations	$ 0.48	$ 1.82	$ 0.61	$ (0.31)	$ 2.59
Discontinued operations	—	—	(0.01)	—	(0.01)
Net income	$ 0.48	$ 1.82	$ 0.60	$ (0.31)	$ 2.58
Diluted earnings (loss) per share attributable to HealthSouth common shareholders: [c]					
Continuing operations	$ 0.48	$ 1.66	$ 0.59	$ (0.31)	$ 2.59
Discontinued operations	—	—	(0.01)	—	(0.01)
Net income	$ 0.48	$ 1.66	$ 0.58	$ (0.31)	$ 2.58

(a) We define operating earnings as income from continuing operations attributable to HealthSouth before (1) loss on early extinguishment of debt; (2) interest expense and amortization of debt discounts and fees; (3) other income; and (4) income tax expense or benefit.

(b) Per share amounts may not sum due to the weighted average common shares outstanding during each quarter compared to the weighted average common shares outstanding during the entire year.

(c) During the first quarter of 2013, adding back the dividends for the *Convertible perpetual preferred stock* to our *Income from continuing operations attributable to HealthSouth common shareholders* causes a per share increase when calculating diluted earnings per common share resulting in an antidilutive per share amount. For the fourth quarter of 2013, adding back amounts related to the repurchase of our preferred stock to our *Income from continuing operations attributable to HealthSouth common shareholders* causes a per share increase when calculating diluted earnings per common share resulting in an antidilutive per share amount. Therefore, basic and diluted earnings (loss) per common share are the same for these quarters.

20. Condensed Consolidating Financial Information:

The accompanying condensed consolidating financial information has been prepared and presented pursuant to SEC Regulation S-X, Rule 3-10, "Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered." Each of the subsidiary guarantors is 100% owned by HealthSouth, and all guarantees are full and unconditional and joint and several, subject to certain customary conditions for release. HealthSouth's investments in its consolidated subsidiaries, as well as guarantor subsidiaries' investments in nonguarantor subsidiaries and nonguarantor subsidiaries' investments in guarantor subsidiaries, are presented under the equity method of accounting with the related investment presented within the line items *Intercompany receivable* and *Intercompany payable* in the accompanying condensed consolidating balance sheets.

The terms of our credit agreement allow us to declare and pay cash dividends on our common stock so long as: (1) we are not in default under our credit agreement and (2) our senior secured leverage ratio (as defined in our credit agreement) remains less than or equal to 1.75x. The terms of our senior note indenture allow us to declare and pay cash dividends on our common stock so long as (1) we are not in default, (2) the consolidated coverage ratio (as defined in the indenture) exceeds 2x or we are otherwise allowed under the indenture to incur debt, and (3) we have capacity under the indenture's restricted payments covenant to declare and pay dividends. See Note 8, *Long-term Debt*.

As described in Note 10, *Convertible Perpetual Preferred Stock*, our preferred stock generally provides for the payment of cash dividends, subject to certain limitations. Our credit agreement and our senior note indenture do not limit the payment of dividends on the preferred stock.

Periodically, certain wholly owned subsidiaries of HealthSouth make dividends or distributions of available cash and/or intercompany receivable balances to their parents. In addition, HealthSouth makes contributions to certain wholly owned subsidiaries. When made, these dividends, distributions, and contributions impact the *Intercompany receivable*, *Intercompany payable*, and *HealthSouth shareholders' equity* line items in the accompanying condensed consolidating balance sheet but have no impact on the consolidated financial statements of HealthSouth Corporation.

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2014				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net operating revenues	$ 16.1	$ 1,719.1	$ 761.1	$ (90.4)	$ 2,405.9
Less: Provision for doubtful accounts	—	(22.3)	(9.3)	—	(31.6)
Net operating revenues less provision for doubtful accounts	16.1	1,696.8	751.8	(90.4)	2,374.3
Operating expenses:					
Salaries and benefits	22.3	795.7	358.8	(15.1)	1,161.7
Other operating expenses	21.6	246.7	120.1	(36.8)	351.6
Occupancy costs	4.2	58.2	17.7	(38.5)	41.6
Supplies	—	78.6	33.3	—	111.9
General and administrative expenses	124.8	—	—	—	124.8
Depreciation and amortization	9.7	71.9	26.1	—	107.7
Government, class action, and related settlements	(1.7)	—	—	—	(1.7)
Professional fees—accounting, tax, and legal	9.3	—	—	—	9.3
Total operating expenses	190.2	1,251.1	556.0	(90.4)	1,906.9
Loss on early extinguishment of debt	13.2	—	—	—	13.2
Interest expense and amortization of debt discounts and fees	99.8	7.8	2.8	(1.2)	109.2
Other income	(0.7)	(28.5)	(3.2)	1.2	(31.2)
Equity in net income of nonconsolidated affiliates	—	(10.7)	—	—	(10.7)
Equity in net income of consolidated affiliates	(314.0)	(30.6)	—	344.6	—
Management fees	(107.9)	82.2	25.7	—	—
Income from continuing operations before income tax (benefit) expense	135.5	425.5	170.5	(344.6)	386.9
Provision for income tax (benefit) expense	(80.8)	148.0	43.5	—	110.7
Income from continuing operations	216.3	277.5	127.0	(344.6)	276.2
Income (loss) from discontinued operations, net of tax	5.7	—	(0.2)	—	5.5
Net income	222.0	277.5	126.8	(344.6)	281.7
Less: Net income attributable to noncontrolling interests	—	—	(59.7)	—	(59.7)
Net income attributable to HealthSouth	$ 222.0	$ 277.5	$ 67.1	$ (344.6)	$ 222.0
Comprehensive income	$ 221.6	$ 277.5	$ 126.8	$ (344.6)	$ 281.3
Comprehensive income attributable to HealthSouth	$ 221.6	$ 277.5	$ 67.1	$ (344.6)	$ 221.6

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2013				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net operating revenues	$ 12.2	$ 1,622.4	$ 709.8	$ (71.2)	$ 2,273.2
Less: Provision for doubtful accounts	—	(18.3)	(7.7)	—	(26.0)
Net operating revenues less provision for doubtful accounts	12.2	1,604.1	702.1	(71.2)	2,247.2
Operating expenses:					
Salaries and benefits	12.1	757.7	334.4	(14.5)	1,089.7
Other operating expenses	10.8	238.5	107.5	(33.8)	323.0
Occupancy costs	4.1	48.3	17.5	(22.9)	47.0
Supplies	—	73.8	31.6	—	105.4
General and administrative expenses	119.1	—	—	—	119.1
Depreciation and amortization	8.8	65.1	20.8	—	94.7
Government, class action, and related settlements	(23.5)	—	—	—	(23.5)
Professional fees—accounting, tax, and legal	9.5	—	—	—	9.5
Total operating expenses	140.9	1,183.4	511.8	(71.2)	1,764.9
Loss on early extinguishment of debt	2.4	—	—	—	2.4
Interest expense and amortization of debt discounts and fees	90.4	8.1	3.1	(1.2)	100.4
Other income	(1.0)	(1.2)	(3.5)	1.2	(4.5)
Equity in net income of nonconsolidated affiliates	(3.6)	(7.5)	(0.1)	—	(11.2)
Equity in net income of consolidated affiliates	(268.0)	(20.6)	—	288.6	—
Management fees	(102.3)	78.6	23.7	—	—
Income from continuing operations before income tax (benefit) expense	153.4	363.3	167.1	(288.6)	395.2
Provision for income tax (benefit) expense	(169.0)	134.4	47.3	—	12.7
Income from continuing operations	322.4	228.9	119.8	(288.6)	382.5
Income (loss) from discontinued operations, net of tax	1.2	(0.8)	(1.5)	—	(1.1)
Net income	323.6	228.1	118.3	(288.6)	381.4
Less: Net income attributable to noncontrolling interests	—	—	(57.8)	—	(57.8)
Net income attributable to HealthSouth	$ 323.6	$ 228.1	$ 60.5	$ (288.6)	$ 323.6
Comprehensive income	$ 322.1	$ 228.1	$ 118.3	$ (288.6)	$ 379.9
Comprehensive income attributable to HealthSouth	$ 322.1	$ 228.1	$ 60.5	$ (288.6)	$ 322.1

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Operations

	For the Year Ended December 31, 2012				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net operating revenues	$ 9.0	$ 1,562.8	$ 649.3	$ (59.2)	$ 2,161.9
Less: Provision for doubtful accounts	(0.3)	(18.0)	(8.7)	—	(27.0)
Net operating revenues less provision for doubtful accounts	8.7	1,544.8	640.6	(59.2)	2,134.9
Operating expenses:					
Salaries and benefits	19.8	735.4	308.6	(13.6)	1,050.2
Other operating expenses	10.6	224.8	97.4	(29.0)	303.8
Occupancy costs	4.1	44.5	16.6	(16.6)	48.6
Supplies	0.1	73.3	29.0	—	102.4
General and administrative expenses	117.9	—	—	—	117.9
Depreciation and amortization	8.6	57.1	16.8	—	82.5
Government, class action, and related settlements	(3.5)	—	—	—	(3.5)
Professional fees—accounting, tax, and legal	16.1	—	—	—	16.1
Total operating expenses	173.7	1,135.1	468.4	(59.2)	1,718.0
Loss on early extinguishment of debt	4.0	—	—	—	4.0
Interest expense and amortization of debt discounts and fees	85.1	7.5	2.6	(1.1)	94.1
Other income	(1.2)	(5.0)	(3.4)	1.1	(8.5)
Equity in net income of nonconsolidated affiliates	(4.3)	(8.4)	—	—	(12.7)
Equity in net income of consolidated affiliates	(258.6)	(21.5)	—	280.1	—
Management fees	(97.8)	75.8	22.0	—	—
Income from continuing operations before income tax (benefit) expense	107.8	361.3	151.0	(280.1)	340.0
Provision for income tax (benefit) expense	(75.9)	146.2	38.3	—	108.6
Income from continuing operations	183.7	215.1	112.7	(280.1)	231.4
Income from discontinued operations, net of tax	1.3	1.3	1.9	—	4.5
Net income	185.0	216.4	114.6	(280.1)	235.9
Less: Net income attributable to noncontrolling interests	—	—	(50.9)	—	(50.9)
Net income attributable to HealthSouth	$ 185.0	$ 216.4	$ 63.7	$ (280.1)	$ 185.0
Comprehensive income	$ 186.6	$ 216.4	$ 114.6	$ (280.1)	$ 237.5
Comprehensive income attributable to HealthSouth	$ 186.6	$ 216.4	$ 63.7	$ (280.1)	$ 186.6

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Balance Sheet

	As of December 31, 2014				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Assets					
Current assets:					
Cash and cash equivalents	$ 41.9	$ 1.5	$ 23.3	$ —	$ 66.7
Restricted cash	—	—	45.6	—	45.6
Accounts receivable, net	—	202.6	120.6	—	323.2
Deferred income tax assets	125.0	39.8	23.6	—	188.4
Prepaid expenses and other current assets	30.9	15.1	35.5	(18.8)	62.7
Total current assets	197.8	259.0	248.6	(18.8)	686.6
Property and equipment, net	16.1	752.0	251.6	—	1,019.7
Goodwill	—	279.6	804.4	—	1,084.0
Intangible assets, net	11.3	50.6	244.2	—	306.1
Deferred income tax assets	163.3	17.5	(51.4)	—	129.4
Other long-term assets	461.3	42.5	64.3	(385.1)	183.0
Intercompany receivable and investments in consolidated affiliates	1,898.7	—	—	(1,898.7)	—
Total assets	$ 2,748.5	$ 1,401.2	$ 1,561.7	$ (2,302.6)	$ 3,408.8
Liabilities and Shareholders' Equity					
Current liabilities:					
Current portion of long-term debt	$ 27.9	$ 4.2	$ 6.2	$ (17.5)	$ 20.8
Accounts payable	9.3	29.5	14.6	—	53.4
Accrued payroll	17.5	55.6	50.2	—	123.3
Accrued interest payable	19.2	1.8	0.2	—	21.2
Other current liabilities	70.4	15.2	61.3	(1.3)	145.6
Total current liabilities	144.3	106.3	132.5	(18.8)	364.3
Long-term debt, net of current portion	1,993.7	83.9	418.3	(385.1)	2,110.8
Self-insured risks	22.9	—	75.8	—	98.7
Other long-term liabilities	21.2	12.7	3.7	—	37.6
Intercompany payable	—	368.7	195.5	(564.2)	—
	2,182.1	571.6	825.8	(968.1)	2,611.4
Commitments and contingencies					
Convertible perpetual preferred stock	93.2	—	—	—	93.2
Redeemable noncontrolling interests	—	—	84.7	—	84.7
Shareholders' equity:					
HealthSouth shareholders' equity	473.2	829.6	504.9	(1,334.5)	473.2
Noncontrolling interests	—	—	146.3	—	146.3
Total shareholders' equity	473.2	829.6	651.2	(1,334.5)	619.5
Total liabilities and shareholders' equity	$ 2,748.5	$ 1,401.2	$ 1,561.7	$ (2,302.6)	$ 3,408.8

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Balance Sheet

	As of December 31, 2013				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Assets					
Current assets:					
Cash and cash equivalents	$ 60.5	$ 2.3	$ 1.7	$ —	$ 64.5
Restricted cash	1.0	—	51.4	—	52.4
Accounts receivable, net	—	184.7	77.1	—	261.8
Deferred income tax assets	85.5	34.5	19.0	—	139.0
Prepaid expenses and other current assets	36.0	15.8	29.4	(18.5)	62.7
Total current assets	183.0	237.3	178.6	(18.5)	580.4
Property and equipment, net	16.3	698.5	195.7	—	910.5
Goodwill	—	279.6	177.3	—	456.9
Intangible assets, net	18.1	49.6	20.5	—	88.2
Deferred income tax assets	288.8	24.5	41.0	—	354.3
Other long-term assets	64.6	27.1	52.4	—	144.1
Intercompany receivable and investments in consolidated affiliates	1,438.8	—	—	(1,438.8)	—
Total assets	$ 2,009.6	$ 1,316.6	$ 665.5	$ (1,457.3)	$ 2,534.4
Liabilities and Shareholders' Equity					
Current liabilities:					
Current portion of long-term debt	$ 19.4	$ 3.8	$ 6.6	$ (17.5)	$ 12.3
Accounts payable	15.1	32.6	14.2	—	61.9
Accrued payroll	23.1	47.8	19.9	—	90.8
Accrued interest payable	22.9	0.8	0.1	—	23.8
Other current liabilities	65.1	18.6	40.1	(1.0)	122.8
Total current liabilities	145.6	103.6	80.9	(18.5)	311.6
Long-term debt, net of current portion	1,381.7	88.1	35.4	—	1,505.2
Self-insured risks	23.2	—	75.0	—	98.2
Other long-term liabilities	21.3	17.4	5.3	—	44.0
Intercompany payable	—	299.2	228.9	(528.1)	—
	1,571.8	508.3	425.5	(546.6)	1,959.0
Commitments and contingencies					
Convertible perpetual preferred stock	93.2	—	—	—	93.2
Redeemable noncontrolling interests	—	—	13.5	—	13.5
Shareholders' equity:					
HealthSouth shareholders' equity	344.6	808.3	102.4	(910.7)	344.6
Noncontrolling interests	—	—	124.1	—	124.1
Total shareholders' equity	344.6	808.3	226.5	(910.7)	468.7
Total liabilities and shareholders' equity	$ 2,009.6	$ 1,316.6	$ 665.5	$ (1,457.3)	$ 2,534.4

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2014				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net cash provided by operating activities	$ 21.9	$ 260.1	$ 162.9	$ —	$ 444.9
Cash flows from investing activities:					
Acquisition of businesses, net of cash acquired	(674.6)	—	(20.2)	—	(694.8)
Purchases of property and equipment	(15.6)	(124.0)	(31.3)	—	(170.9)
Capitalized software costs	(8.6)	(1.4)	(7.0)	—	(17.0)
Proceeds from sale of restricted investments	—	—	0.3	—	0.3
Purchases of restricted investments	—	—	(3.5)	—	(3.5)
Net change in restricted cash	1.0	—	5.8	—	6.8
Other	—	(0.7)	2.9	—	2.2
Net cash used in investing activities	(697.8)	(126.1)	(53.0)	—	(876.9)
Cash flows from financing activities:					
Principal borrowings on term loan facilities	450.0	—	—	—	450.0
Proceeds from bond issuance	175.0	—	—	—	175.0
Principal payments on debt, including pre-payments	(298.0)	(1.5)	(3.1)	—	(302.6)
Borrowings on revolving credit facility	440.0	—	—	—	440.0
Payments on revolving credit facility	(160.0)	—	—	—	(160.0)
Principal payments under capital lease obligations	(0.3)	(2.5)	(3.3)	—	(6.1)
Repurchases of common stock, including fees and expenses	(43.1)	—	—	—	(43.1)
Dividends paid on common stock	(65.8)	—	—	—	(65.8)
Dividends paid on convertible perpetual preferred stock	(6.3)	—	—	—	(6.3)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(54.1)	—	(54.1)
Proceeds from exercising stock warrants	6.3	—	—	—	6.3
Other	0.9	—	—	—	0.9
Change in intercompany advances	158.6	(130.8)	(27.8)	—	—
Net cash provided by (used in) financing activities	657.3	(134.8)	(88.3)	—	434.2
(Decrease) increase in cash and cash equivalents	(18.6)	(0.8)	21.6	—	2.2
Cash and cash equivalents at beginning of year	60.5	2.3	1.7	—	64.5
Cash and cash equivalents at end of year	$ 41.9	$ 1.5	$ 23.3	$ —	$ 66.7
Supplemental schedule of noncash investing activity:					
Equity rollover from Encompass management	$ —	$ —	$ 64.5	$ —	$ 64.5

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2013				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net cash provided by operating activities	$ 113.2	$ 235.7	$ 121.4	$ —	$ 470.3
Cash flows from investing activities:					
Acquisition of businesses, net of cash acquired	—	(28.9)	—	—	(28.9)
Purchases of property and equipment	(2.8)	(167.9)	(24.5)	—	(195.2)
Capitalized software costs	(6.0)	(11.1)	(4.2)	—	(21.3)
Proceeds from sale of restricted investments	—	—	16.9	—	16.9
Proceeds from sale of Digital Hospital	10.8	—	—	—	10.8
Purchases of restricted investments	—	—	(9.2)	—	(9.2)
Net change in restricted cash	(0.2)	—	(2.9)	—	(3.1)
Other	—	0.9	(0.4)	—	0.5
Net cash provided by investing activities of discontinued operations	—	3.1	0.2	—	3.3
Net cash provided by (used in) investing activities	1.8	(203.9)	(24.1)	—	(226.2)
Cash flows from financing activities:					
Principal payments on debt, including pre-payments	(59.5)	(1.3)	(1.7)	—	(62.5)
Principal borrowings on notes	—	—	15.2	—	15.2
Borrowings on revolving credit facility	197.0	—	—	—	197.0
Payments on revolving credit facility	(152.0)	—	—	—	(152.0)
Principal payments under capital lease obligations	(0.3)	(6.3)	(3.5)	—	(10.1)
Repurchases of common stock, including fees and expenses	(234.1)	—	—	—	(234.1)
Repurchases of convertible perpetual preferred stock, including fees	(2.8)	—	—	—	(2.8)
Dividends paid on common stock	(15.7)	—	—	—	(15.7)
Dividends paid on convertible perpetual preferred stock	(23.0)	—	—	—	(23.0)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(46.3)	—	(46.3)
Contributions from consolidated affiliates	—	—	1.6	—	1.6
Proceeds from exercising stock warrants	15.3	—	—	—	15.3
Other	5.0	—	—	—	5.0
Change in intercompany advances	84.3	(22.2)	(62.1)	—	—
Net cash used in financing activities	(185.8)	(29.8)	(96.8)	—	(312.4)
(Decrease) increase in cash and cash equivalents	(70.8)	2.0	0.5	—	(68.3)
Cash and cash equivalents at beginning of year	131.3	0.3	1.2	—	132.8
Cash and cash equivalents at end of year	$ 60.5	$ 2.3	$ 1.7	$ —	$ 64.5
Supplemental schedule of noncash financing activities:					
Convertible debt issued	$ 320.0	$ —	$ —	$ —	$ 320.0
Repurchase of preferred stock	(320.0)	—	—	—	(320.0)

HealthSouth Corporation and Subsidiaries

Notes to Consolidated Financial Statements

Condensed Consolidating Statement of Cash Flows

	For the Year Ended December 31, 2012				
	HealthSouth Corporation	Guarantor Subsidiaries	Nonguarantor Subsidiaries	Eliminating Entries	HealthSouth Consolidated
			(In Millions)		
Net cash provided by operating activities	$ 31.3	$ 252.4	$ 127.8	$ —	$ 411.5
Cash flows from investing activities:					
Acquisition of businesses, net of cash acquired	—	(3.1)	—	—	(3.1)
Purchases of property and equipment	(4.8)	(98.4)	(37.6)	—	(140.8)
Capitalized software costs	(8.5)	(7.2)	(3.2)	—	(18.9)
Proceeds from sale of restricted investments	—	—	0.3	—	0.3
Purchases of restricted investments	—	—	(9.1)	—	(9.1)
Net change in restricted cash	(0.1)	—	(13.9)	—	(14.0)
Other	(0.3)	(0.8)	0.2	—	(0.9)
Net cash provided by investing activities of discontinued operations	4.4	3.3	—	—	7.7
Net cash used in investing activities	(9.3)	(106.2)	(63.3)	—	(178.8)
Cash flows from financing activities:					
Proceeds from bond issuance	275.0	—	—	—	275.0
Principal payments on debt, including pre-payments	(164.9)	(1.3)	—	—	(166.2)
Borrowings on revolving credit facility	135.0	—	—	—	135.0
Payments on revolving credit facility	(245.0)	—	—	—	(245.0)
Principal payments under capital lease obligations	(0.3)	(8.9)	(2.9)	—	(12.1)
Repurchases of convertible perpetual preferred stock, including fees	(46.0)	—	—	—	(46.0)
Dividends paid on convertible perpetual preferred stock	(24.6)	—	—	—	(24.6)
Distributions paid to noncontrolling interests of consolidated affiliates	—	—	(49.3)	—	(49.3)
Contributions from consolidated affiliates	—	—	10.5	—	10.5
Other	0.2	—	(7.5)	—	(7.3)
Change in intercompany advances	153.9	(137.0)	(16.9)	—	—
Net cash provided by (used in) financing activities	83.3	(147.2)	(66.1)	—	(130.0)
Increase (decrease) in cash and cash equivalents	105.3	(1.0)	(1.6)	—	102.7
Cash and cash equivalents at beginning of year	26.0	1.3	2.8	—	30.1
Cash and cash equivalents at end of year	$ 131.3	$ 0.3	$ 1.2	$ —	$ 132.8

EXHIBIT LIST

No.	Description
2.1	Stock Purchase Agreement, dated as of November 23, 2014, by and among EHHI Holdings, Inc., the sellers party thereto, HealthSouth Corporation, HealthSouth Home Health Corporation, and the sellers' representative named therein.#
2.2	Rollover Stock Agreement, dated as of November 23, 2014, by and among HealthSouth Corporation, HealthSouth Home Health Holdings, Inc., and the selling stockholders of EHHI Holdings, Inc. named therein.#
3.1	Restated Certificate of Incorporation of HealthSouth Corporation, as filed in the Office of the Secretary of State of the State of Delaware on May 21, 1998.*
3.2	Certificate of Amendment to the Restated Certificate of Incorporation of HealthSouth Corporation, as filed in the Office of the Secretary of State of the State of Delaware on October 25, 2006 (incorporated by reference to Exhibit 3.1 to HealthSouth's Current Report on Form 8-K filed on October 31, 2006).
3.3	Amended and Restated Bylaws of HealthSouth Corporation, effective as of October 30, 2009 (incorporated by reference to Exhibit 3.3 to HealthSouth's Quarterly Report on Form 10-Q filed on November 4, 2009).
3.4	Certificate of Designations of 6.50% Series A Convertible Perpetual Preferred Stock, as filed with the Secretary of State of the State of Delaware on March 7, 2006 (incorporated by reference to Exhibit 3.1 to HealthSouth's Current Report on Form 8-K filed on March 9, 2006).
4.1	Warrant Agreement, dated as of September 30, 2009, among HealthSouth Corporation and Computershare Inc. and Computershare Trust Company, N.A., jointly and severally as warrant agent (incorporated by reference to Exhibit 4.1 to HealthSouth's Registration Statement on Form 8-A filed on October 1, 2009).
4.2.1	Indenture, dated as of December 1, 2009, between HealthSouth Corporation and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to HealthSouth's 8.125% Senior Notes due 2020, 7.250% Senior Notes due 2018, 7.750% Senior Notes due 2022, and 5.75% Senior Notes due 2024 (incorporated by reference to Exhibit 4.7.1 to HealthSouth's Annual Report on Form 10-K filed on February 23, 2010).
4.2.2	First Supplemental Indenture, dated December 1, 2009, among HealthSouth Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to HealthSouth's 8.125% Senior Notes due 2020 (incorporated by reference to Exhibit 4.7.2 to HealthSouth's Annual Report on Form 10-K filed on February 23, 2010).
4.2.3	Third Supplemental Indenture, dated October 7, 2010, among HealthSouth Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to HealthSouth's 7.750% Senior Notes due 2022 (incorporated by reference to Exhibit 4.3 to HealthSouth's Current Report on Form 8-K filed on October 12, 2010).
4.2.4	Fourth Supplemental Indenture, dated September 11, 2012, among HealthSouth Corporation, the Subsidiary Guarantors (as defined therein) and Wells Fargo Bank, National Association, as trustee and successor in interest to The Bank of Nova Scotia Trust Company of New York, relating to HealthSouth's 5.75% Senior Notes due 2024 (incorporated by reference to Exhibit 4.2 to HealthSouth's Current Report on Form 8-K filed on September 11, 2012).
4.3	Indenture, dated November 18, 2013, by and between HealthSouth Corporation and Wells Fargo Bank, National Association, as trustee, relating to HealthSouth's 2.00% Convertible Senior Subordinated Notes due 2043 (incorporated by reference to Exhibit 4.1 to HealthSouth's Current Report on Form 8-K filed on November 19, 2013).
10.1	Stipulation of Partial Settlement, dated as of September 26, 2006, by and among HealthSouth Corporation, the stockholder lead plaintiffs named therein, the bondholder lead plaintiff named therein and the individual settling defendants named therein (incorporated by reference to Exhibit 10.1 to HealthSouth's Current Report on Form 8-K filed on September 27, 2006).

10.2 Stipulation of Settlement with Certain Individual Defendants dated as of September 25, 2006, by and among HealthSouth Corporation, plaintiffs named therein and the individual settling defendants named therein (incorporated by reference to Exhibit 10.3 to HealthSouth's Current Report on Form 8-K filed on September 27, 2006).

10.3.1 HealthSouth Corporation Amended and Restated 2004 Director Incentive Plan.** +

10.3.2 Form of Restricted Stock Unit Agreement (Amended and Restated 2004 Director Incentive Plan).** +

10.4 HealthSouth Corporation Third Amended and Restated Change in Control Benefits Plan (incorporated by reference to Exhibit 10.1 to HealthSouth's Current Report on Form 8-K filed on December 8, 2014). +

10.5.1 HealthSouth Corporation 1995 Stock Option Plan, as amended.* +

10.5.2 Form of Non-Qualified Stock Option Agreement (1995 Stock Option Plan).* +

10.6 Description of the HealthSouth Corporation Senior Management Compensation Recoupment Policy (incorporated by reference to Item 5, "Other Matters," in HealthSouth's Quarterly Report on Form 10-Q filed on November 4, 2009).+

10.7 Description of the HealthSouth Corporation Senior Management Bonus and Long-Term Incentive Plans (incorporated by reference to the section captioned "Executive Compensation – Compensation Discussion and Analysis – Elements of Executive Compensation" in HealthSouth's Definitive Proxy Statement on Schedule 14A filed on April 1, 2014).+

10.8 Description of the annual compensation arrangement for non-employee directors of HealthSouth Corporation (incorporated by reference to the section captioned "Corporate Governance and Board Structure – Compensation of Directors" in HealthSouth's Definitive Proxy Statement on Schedule 14A, filed on April 1, 2014).+

10.9 HealthSouth Corporation Fourth Amended and Restated Executive Severance Plan (incorporated by reference to Exhibit 10.1 to HealthSouth's Quarterly Report on Form 10-Q filed on October 29, 2013).+

10.10 HealthSouth Corporation Nonqualified 401(k) Plan (incorporated by reference to Exhibit 10.1 to HealthSouth's Quarterly Report on Form 10-Q filed on July 29, 2014).+

10.11.1 HealthSouth Corporation 2005 Equity Incentive Plan (incorporated by reference to Exhibit 10 to HealthSouth's Current Report on Form 8-K, filed on November 21, 2005).+

10.11.2 Form of Non-Qualified Stock Option Agreement (2005 Equity Incentive Plan).**+

10.12 Form of Key Executive Incentive Award Agreement.** +

10.13.1 HealthSouth Corporation Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 4(d) to HealthSouth's Registration Statement on Form S-8 filed on August 2, 2011).+

10.13.2 Form of Non-Qualified Stock Option Agreement (2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.28.2 to HealthSouth's Annual Report on Form 10-K filed on February 24, 2009). +

10.13.3 Form of Restricted Stock Agreement (2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.28.3 to HealthSouth's Annual Report on Form 10-K filed on February 24, 2009).+

10.13.4 Form of Performance Share Unit Award (2008 Equity Incentive Plan)(incorporated by reference to Exhibit 10.28.4 to HealthSouth's Annual Report on Form 10-K filed on February 24, 2009).+

10.13.5 Form of Non-Qualified Stock Option Agreement (Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 10.1.2 to HealthSouth's Quarterly Report on Form 10-Q filed on August 4, 2011).+

10.13.6 Form of Restricted Stock Agreement (Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 10.1.3 to HealthSouth's Quarterly Report on Form 10-Q filed on August 4, 2011).+

10.13.7	Form of Performance Share Unit Award (Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 10.1.4 to HealthSouth's Quarterly Report on Form 10-Q filed on August 4, 2011 and the description in Item 5, "Other Items," in HealthSouth's Quarterly Report on Form 10-Q filed on July 30, 2013).+
10.13.8	Form of Restricted Stock Unit Award (Amended and Restated 2008 Equity Incentive Plan (incorporated by reference to Exhibit 10.1.5 to HealthSouth's Quarterly Report on Form 10-Q filed on August 4, 2011).+
10.14	HealthSouth Corporation Directors' Deferred Stock Investment Plan (incorporated by reference to HealthSouth's Annual Report on Form 10-K filed on February 19, 2013).+
10.15	Form of Indemnity Agreement entered into between HealthSouth Corporation and the directors of HealthSouth.* +
10.16	Lease between LAKD HQ, LLC and HealthSouth Corporation, dated March 31, 2008, for corporate office space (incorporated by reference to Exhibit 10.5 to HealthSouth's Quarterly Report on Form 10-Q filed on May 7, 2008).
10.17	Settlement Agreement and Stipulation regarding Fees, dated as of January 13, 2009 (incorporated by reference to Exhibit 99.3 to HealthSouth's Current Report on Form 8-K filed on January 20, 2009).
10.18.1	Third Amended and Restated Credit Agreement, dated August 10, 2012, among HealthSouth Corporation, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, and Morgan Stanley Senior Funding, Inc., as co-documentation agents, and various other lenders from time to time (incorporated by reference to Exhibit 10.1 to HealthSouth's Quarterly Report on Form 10-Q filed on October 26, 2012).
10.18.2	First Amendment to the Third Amended and Restated Credit Agreement, dated June 11, 2013, among HealthSouth Corporation, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, and Morgan Stanley Senior Funding, Inc., as co-documentation agents, and various other lenders from time to time (incorporated by reference to Exhibit 10.1 to HealthSouth's Quarterly Report on Form 10-Q filed on July 30, 2013).
10.18.3	Second Amendment and Additional Tranche Term Loan Amendment to Third Amended and Restated Credit Agreement, dated as of September 22, 2014, among HealthSouth Corporation, Barclays Bank PLC, as administrative agent and collateral agent, Citigroup Global Markets Inc., as syndication agent, Bank of America, N.A., Goldman Sachs Lending Partners LLC, and Morgan Stanley Senior Funding, Inc., as co-documentation agents, and various other lenders from time to time (incorporated by reference to Exhibit 10.1 to HealthSouth's Current Report on Form 8-K filed on September 24, 2014).
10.18.4	Additional Tranche Term Loan Amendment to Third Amended and Restated Credit Agreement, dated as of December 23, 2014, among HealthSouth Corporation, its subsidiary guarantors, the lenders party thereto, and Barclays Bank PLC, as administrative agent (incorporated by reference to Exhibit 10.1 to HealthSouth's Current Report on Form 8-K filed on December 23, 2014).
10.18.5	Amended and Restated Collateral and Guarantee Agreement, dated as of October 26, 2010, among HealthSouth Corporation, its subsidiaries identified herein, and Barclays Bank PLC, as collateral agent (incorporated by reference to Exhibit 10.3 to HealthSouth's Current Report on Form 8-K/A filed on November 23, 2010).
10.19	Homecare Homebase, L.L.C. Restated Client Service and License Agreement, dated December 31, 2014, by and between Homecare Homebase, L.L.C. and EHHI Holdings, Inc.
10.20	Amended and Restated Senior Management Agreement, dated as of November 23, 2014, by and among EHHI Holdings, Inc., April Anthony, HealthSouth Corporation, and solely for purposes of Sections 6(b) and 6(j) thereof, Thoma Cressey Fund VIII, L.P.+
12.1	Computation of Ratios.
21.1	Subsidiaries of HealthSouth Corporation.
23.1	Consent of PricewaterhouseCoopers LLP, Independent Registered Public Accounting Firm.
24.1	Power of Attorney (included as part of signature page).

31.1	Certification of Chief Executive Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Chief Financial Officer required by Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Chief Executive Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Chief Financial Officer pursuant to 18 U.S.C. 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	Sections of the HealthSouth Corporation Annual Report on Form 10-K for the year ended December 31, 2014, formatted in XBRL (eXtensible Business Reporting Language), submitted in the following files:
	101.INS XBRL Instance Document
	101.SCH XBRL Taxonomy Extension Schema Document
	101.CAL XBRL Taxonomy Extension Calculation Linkbase Document
	101.DEF XBRL Taxonomy Extension Definition Linkbase Document
	101.LAB XBRL Taxonomy Extension Label Linkbase Document
	101.PRE XBRL Taxonomy Extension Presentation Linkbase Document

\# Schedules have been omitted pursuant to Item 601(b)(2) of Regulation S-K. A copy of any omitted schedule will be furnished supplementally to the Securities and Exchange Commission upon request.

* Incorporated by reference to HealthSouth's Annual Report on Form 10-K filed with the SEC on June 27, 2005.

** Incorporated by reference to HealthSouth's Annual Report on Form 10-K filed with the SEC on March 29, 2006.

\+ Management contract or compensatory plan or arrangement.

^ Certain portions of this exhibit have been omitted pursuant to a request for confidential treatment. The nonpublic information has been filed separately with the Securities and Exchange Commission pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended.

West Tennessee Healthcare and Related Affiliates

Audited Financial Statements and Supplemental Schedules

June 30, 2014 and 2013

DIXON HUGHES GOODMAN LLP
Certified Public Accountants and Advisors

West Tennessee Healthcare and Related Affiliates

Audited Financial Statements and Supplemental Schedules

Years Ended June 30, 2014 and 2013

Contents

DIXON HUGHES GOODMAN LLP
Certified Public Accountants and Advisors

Report of Independent Auditors

The Board of Trustees
West Tennessee Healthcare and Related Affiliates

Report on the Financial Statements

We have audited the accompanying financial statements of West Tennessee Healthcare and Related Affiliates (the "Company"), as of and for the year ended June 30, 2014, and the related notes to the financial statements, which collectively comprise the Company's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

999 South Shady Grove Road, Suite 400, Memphis, TN 38120 | T 901.761.3000 | F 901.761.9667 | dhgllp.com

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Company as of June 30, 2014, and the changes in its financial position and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

New Accounting Pronouncements

As discussed in Note 2 to the financial statements, the Company adopted the provisions of Governmental Accounting Standards Board ("GASB") Statement No. 65, *Items Previously Reported as Assets and Liabilities*, in 2014. As a result of adopting these standards, the Company restated the beginning net position for the write-off of bond issuance costs and reclassified the deferred loss on bond refunding to deferred outflows of resources.

Adjustments to Prior Period Financial Statements

The financial statements of West Tennessee Healthcare and Related Affiliates as of June 30, 2013, were audited by other auditors whose report dated October 13, 2013, expressed an unmodified opinion on those statements. As discussed in Note 2 to the financial statements, the Company has adjusted its 2013 financial statements to retrospectively apply the change in accounting required by GASB Statement No. 65. The other auditors reported on the financial statements before the retrospective adjustment.

As part of our audit of the 2014 financial statements, we also audited the adjustments to the 2013 financial statements to retrospectively apply the change in accounting as described in Note 2. In our opinion, such adjustments are appropriate and have been properly applied. We were not engaged to audit, review, or apply any procedures to the Company's 2013 financial statements other than with respect to the adjustments and, accordingly, we do not express an opinion or any other form of assurance on the 2013 financial statements as a whole.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 4 through 10 and the pension and post employment benefits information on pages 45 through 46 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the GASB, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The roster of governance and management officials on page 11 and the deductions from gross patient service revenues information on pages 47 through 48 are presented for purposes of additional analysis and are not a required part of the basic financial statements.

The deductions from gross patient service revenues information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

The roster of governance and management officials has not been subjected to the auditing procedures applied in the audit of the basic financial statements and, accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated October 24, 2014, on our consideration of the Company's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Company's internal control over financial reporting and compliance.

Dixon Hughes Goodman LLP

October 24, 2014

West Tennessee Healthcare and Related Affiliates

Management's Discussion and Analysis

Years Ended June 30, 2014 and 2013

This section of the financial statements of West Tennessee Healthcare and Related Affiliates (the "Company") presents management's analysis of the Company's financial performance during the fiscal years ended June 30, 2014 and 2013.

Financial Highlights

2014

- The Company's results from operations, including interest expense, fell below budgeted expectations in 2014 with an operating margin of 1%.

- Total operating revenues were 2% above the prior year, an increase of approximately $14.9 million. The increase was due to several factors, most notably an increase in surgery volumes for the flagship hospital and having a full year of volume related to new and expanded services.

- Total expenses were up 4% when compared to the prior year, with a 3% increase in Salaries and Benefits expense. The Company experienced a 7% increase in Supply and Other administrative costs driven primarily by the opening of the Kirkland Cancer Center and transition costs related to a realignment of services in Gibson County where three small community hospitals were replaced with one hospital, an outpatient medical center and an emergency department satellite location of the flagship hospital. The Company also had over $8 million in non-recurring costs with a loss in 2014 of $5.9 million due to a write-down in value of a leased office building vacated during the year and $2.7 million in non-recurring costs for a voluntary retirement incentive program.

- The Company's non-operating revenue was up significantly with improved market conditions for the Company's investments.

2013

- The Company's results from operations, including interest expense, met budgeted expectations in 2013 with an operating margin of 2.2%.

- Total operating revenues were 3.4% above the prior year, an increase of approximately $20 million. The increase was due to several factors, most notably an increase in cardiology and Rehabilitation Center volumes for the flagship hospital and the addition of some new services during the year.

- Total operating expenses were up 2%, with a 1% increase in Salaries and Benefits expense resulting from routine staffing and raises and an 8.6% increase in supply costs driven primarily by the increase in cardiology volume.

- The Company's non-operating revenue was up significantly with improved market conditions for the Company's investments.

Overview of the Financial Statements

The financial statements consist of two parts: management's discussion and analysis and the basic financial statements. The basic financial statements also include notes and required supplementary information that explain in more detail some of the information in the financial statements.

Required Basic Financial Statements

The Company reports financial information about the Company using accounting methods similar to those used by private sector companies. These statements offer short-term and long-term financial information about its activities. The statements of net position include all the Company's assets and liabilities and provide information about the nature and amounts of investments in resources (assets) and the obligations to Company creditors (liabilities). The assets and liabilities are presented in a classified format, which distinguishes between current and long-term assets and liabilities. These statements also provide the basis for computing rate of return, evaluating the capital structure of the Company and assessing the liquidity and financial flexibility of the Company.

All of the current year's revenues and expenses are accounted for in the statements of revenues and expenses and changes in net position. These statements measure the performance of the Company's operations over the past year and can be used to determine whether the Company has successfully recovered all its costs through the services provided, as well as its profitability and creditworthiness.

The final required statement is the statement of cash flows. The primary purpose of this statement is to provide information about the Company's cash receipts and cash payments during the reporting period. The statement reports cash receipts, cash payments, and net changes in cash resulting from operating, investing, non-capital financing and financing activities, and provides information as to where cash came from, what cash was used for, and what the change in the cash balance was during the reporting period.

Financial Analysis

Our analysis of the financial statements of the Company begins below. One of the most important questions asked about the Company's finances is, "Is the Company as a whole better off or worse off as a result of the year's activities?" The statements of net position and the statements of revenues, expenses, and changes in net position report information about the Company's activities in a way that will help answer this question. These statements report the net position of the Company and changes in them. You can think of the Company's net position – the difference between assets and liabilities – as one way to measure financial health or financial position. Over time, increases or decreases in the Company's net position are one indicator of whether its financial health is improving

or deteriorating. However, you will need to consider other non-financial factors such as changes in interest rates, economic conditions, regulations and new or changed government legislation.

Table A-1
Condensed Statements of Net Position (in millions of dollars)

	June 30			Dollar Increase (Decrease)	Percentage Increase (Decrease)	Dollar Increase (Decrease)	Percentage Increase (Decrease)
	2014	2013	2012	2013-2014	2013-2014	2012-2013	2012-2013
Current assets	$ 158.9	$ 148.5	$ 139.3	$ 10.4	7%	$ 9.2	7%
Capital assets, net	385.1	391.8	386.6	(6.7)	(2)%	5.2	1%
Other non-current assets	367.0	347.7	331.8	19.3	6%	15.9	5%
Total assets	911.0	888.0	857.7	23.0	3%	30.3	4%
Deferred outflows of resources	5.4	6.0	6.6	(0.6)	(10)%	(0.6)	(9)%
Total assets and deferred outflows	$ 916.4	$ 894.0	$ 864.3	$ 22.4	3%	$ 29.7	3%
Current liabilities	$ 63.4	$ 72.1	$ 66.5	$ (8.7)	(12)%	$ 5.6	8%
Non-current liabilities	284.6	289.5	294.1	(4.9)	(2)%	(4.6)	(2)%
Total liabilities	348.0	361.6	360.6	(13.6)	(4)%	1.0	(0.25)%
Net position:							
Unrestricted	421.7	381.1	366.1	40.6	11%	15.0	4%
Invested in capital assets, net of related financing	119.7	124.4	115.5	(4.7)	(4)%	8.9	8%
Restricted	27.0	26.9	22.1	0.1	0%	4.8	22%
Total net position	568.4	532.4	503.7	36.0	7%	28.7	6%
Total liabilities and net position	$ 916.4	$ 894.0	$ 864.3	$ 22.4	3%	$ 29.7	3%

As indicated in Table A-1, net position increased from fiscal 2013 by $36 million or 7% with the Company's financial performance in fiscal year 2014.

1. Total assets increased by $23 million or 3% with significant growth in the value of the investment portfolio and growth in accounts receivable arising from volume and revenue growth.

2. Total liabilities decreased by $13.6 million or 4% due to regular debt payments and routine activity.

As indicated in Table A-1, net position increased from fiscal 2012 by $28.7 million or 6% with the Company's financial performance in fiscal year 2013.

1. Total assets increased by $30.3 million or 4% with significant growth in the value of the investment portfolio and growth in Accounts Receivable arising from volume and revenue growth.

2. Total liabilities remained relatively flat, increasing by $1 million or 0.25% with routine activity.

Table A-2
Condensed Statements of Revenues and Expenses, and Changes in Net Position
(in millions of dollars)

	Year Ended June 30			Dollar Increase (Decrease)	Percentage Increase (Decrease)	Dollar Increase (Decrease)	Percentage Increase (Decrease)
	2014	2013	2012	2013-2014	2013-2014	2012-2013	2012-2013
Net patient service revenues	$ 588.2	$ 569.1	$ 553.0	$ 19.1	3%	$ 16.1	3%
Other operating revenues	40.7	44.9	40.9	(4.2)	(9)%	4.0	10%
Total operating revenues	628.9	614.0	593.9	14.9	2%	20.1	3%
Salaries and benefits	327.7	319.7	317.7	8.0	3%	2.0	1%
Supplies and other expenses	230.0	215.0	203.4	15.0	7%	11.6	9%
Depreciation and amortization	47.7	48.0	49.6	(0.3)	(1)%	(1.6)	0%
Total expenses	605.4	582.7	570.7	22.7	4%	12.0	2%
Income from operations	23.5	31.3	23.2	(7.8)	(26)%	8.1	35%
Net nonoperating revenues and expenses	12.5	(2.5)	(17.8)	15.0	(600)%	15.3	(86)%
Change in net position	36.0	28.8	5.4	7.2	25%	23.4	433%
Beginning net position	532.4	503.6	498.2	28.8	6%	5.4	1%
Ending net position	$ 568.4	$ 532.4	$ 503.6	$ 36.0	(7)%	$ 28.8	6%

While the statements of net position show the change in financial position or net position, the statements of revenues and expenses and changes in net position, as indicated above, provide answers as to the nature and source of these changes (i.e., the financial result of current year operations).

Operating revenues increased by $14.9 million or 2% from 2013 to 2014.

1. The increase was driven primarily by improved surgery volumes and opening of Kirkland Cancer Center, and offset by reduced impatient volume overall.

2. The Company earned $5.5 million in incentive payments for the meaningful use of electronic health records.

Operating revenues increased by $20.1 million or 3% from 2012 to 2013. The increase was driven primarily by improved cardiology volumes.

1. Inpatient discharges remained relatively flat with a 0.3% decrease. Although inpatient volumes were flat, patient revenue improved with the increase in cardiology cases. Surgical volumes were flat compared to the prior year.

2. The Company earned $8.1 million in incentive payments for the meaningful use of electronic health records.

Operating expense increased by $22.7 million or 4% when comparing 2014 to 2013.

1. Total salaries and benefits expense increased by $8 million or 3% due to several factors, most notably due to $2.7 million in salary expenses related to a voluntary retirement initiative and an increase in FTEs related to new and expanded services, compounded by higher medical, dental and vision claims.

2. The Company recognized a loss in fiscal year 2014 of $5,946,138 due to a write-down in value of a building formerly leased to the Jackson Clinic. During the fiscal year, the building became vacant. The amount of the reduction in value relates to portions of the building determined to be unusable through space planning work conducted during the fiscal year.

3. Other expenses increased by $12.7 million or 14% with the opening of Kirkland Cancer Center and transition costs related to a realignment of services in Gibson County where two inpatient facilities were closed and volumes declined in advance of the closure.

Operating expense increased by $12 million or 2% when comparing 2013 to 2012.

1. Total salaries and benefits expense increased by $2 million or 1% due to several factors, most notably routine employee rate adjustments awarded in September 2012.

2. Total supply expenses for the Company increased by $10.1 million or 9% due to improving volumes particularly for cardiology services, where supply costs per case are generally higher. In addition, drug costs increased with the temporary loss of 340b pricing during the year due to a change in enrollment status.

3. Other expenses decreased by $0.1 million or 1.0% with changes to co-management arrangements, enhanced case management services and routine inflation of equipment and software maintenance costs.

Capital Assets and Long-Term Debt

Capital Assets

As of June 30, 2014, the Company had $385.1 million invested in a variety of capital assets, as reflected in Table A-3, which represents a net decrease (additions, disposals and depreciation) of $6.7 million or 2% from the end of last year.

Table A-3
Capital Assets (in millions of dollars)

	June 30 2014	2013
Land and land improvements	$ 48.8	$ 46.9
Buildings	303.9	287.3
Equipment	609.3	576.9
Construction in progress	7.7	30.4
Total capital assets	969.7	941.5
Accumulated depreciation	(584.6)	(549.7)
Capital assets, net	$ 385.1	$ 391.8

Long-Term Debt

As of June 30, 2014, the Company had $294.1 million in outstanding long-term debt and as of June 30, 2013, the Company had $299.0 million in outstanding long-term debt. This represents a net decrease of $4.9 million over the prior fiscal year.

For more detailed information regarding the Company's capital assets and long-term debt, please refer to the notes to the financial statements.

Future Outlook

The Board of Trustees and management continue to have a positive outlook for the Company. In the 2014 fiscal year, the Company took important steps to reduce costs, realign services, and improve efficiency, positioning the organization better to respond to continued downward pressure on hospital volume and revenue and the shorter term impact of the absence of Medicaid expansion in Tennessee. The Company continues its commitment to high quality care and an exceptional patient experience, while pursuing business strategies that will strengthen its financial position and ensure

Future Outlook (continued)

its ability to continue to fulfill its mission. The Company continues to develop and evaluate alignment and business strategies to accomplish these objectives.

Requests for Information

This financial report is designed to provide a general overview of the Company's finances. Questions concerning any of the information provided in this report or requests for additional information should be addressed to the Company.

West Tennessee Healthcare and Related Affiliates

Roster of Governance and Management Officials

Years Ended June 30, 2014 and 2013

Governance Officials – Board of Trustees

Name	Title	Principal Occupation
Greg Milam	Chairman	Insurance Services
Vicki Burch	Vice-Chairman	President, West Tennessee Business College
Danny Wheeler	Secretary	Retired, Jackson Energy Authority
Curtis Mansfield		President, First Bank
Phil Bryant		Financial Services

Management Officials

Bobby Arnold	Chief Executive Officer
James Ross	Chief Operating Officer, Vice-President
Jeff Blankenship	Chief Financial Officer, Vice-President
Currie Higgs	General Counsel, Vice-President
Amy Griffin	Compliance Officer, Vice-President
Dr. David Roberts	Chief Medical Officer, Vice-President
Jeff Frieling	Chief Information Officer, Vice-President
Wendie Carlson	Vice-President of Human Resources
Dr. Lisa Piercey	Vice-President of Physician Services
Tina Prescott	Chief Nursing Officer, Vice-President
Catherine Kwasigroh	Vice-President of Hospital Services
Karen Utley	Vice-President of Hospital Services
Deann Montchal	Vice-President of Hospital Services

West Tennessee Healthcare and Related Affiliates

Statements of Net Position

June 30, 2014 and 2013

	2014	2013
Assets		
Current assets:		
Cash and cash equivalents	$ 32,735,522	$ 31,941,021
Accounts receivable:		
Patient accounts receivable, less allowances for doubtful accounts of approximately $38,352,000 and $35,653,000, respectively	102,175,449	87,965,287
Other	4,748,264	10,373,988
Total accounts receivable	106,923,713	98,339,275
Inventories	6,387,918	5,977,317
Prepaid expenses	7,153,657	7,017,543
Restricted assets - current portion	5,660,068	5,190,102
Total current assets	158,860,878	148,465,258
Restricted assets:		
Funded depreciation - buildings	58,617,646	59,770,124
Funded depreciation - equipment	31,517,310	32,136,970
Debt service reserve fund	21,369,360	21,700,684
Project building fund	85,830,289	77,372,432
Operating reserve fund	119,040,758	107,575,318
Contingency fund	9,347,342	8,420,128
High technology fund	11,097,983	9,997,114
	336,820,688	316,972,770
Other assets:		
Goodwill	9,569,318	9,833,045
Wellness Center loan receivable	16,872,584	16,872,584
Other	3,774,341	3,987,500
	30,216,243	30,693,129
Capital assets:		
Land and land improvements	48,841,591	46,884,820
Buildings	303,854,813	287,318,752
Fixed equipment	208,036,305	194,674,706
Moveable equipment	401,299,135	382,290,274
Construction in progress	7,656,848	30,390,343
	969,688,692	941,558,895
Accumulated depreciation	(584,557,697)	(549,722,325)
	385,130,995	391,836,570
Total assets	911,028,804	887,967,727
Deferred outflows of resources		
Deferred charges on refundings	5,398,807	5,990,940
Total deferred outflows of resources	5,398,807	5,990,940
Total assets and deferred outflows of resources	$ 916,427,611	$ 893,958,667

See accompanying notes.

	2014	2013
Liabilities and net position		
Current liabilities:		
Accounts payable	$ 14,334,724	$ 18,133,014
Accrued compensation and related expenses	24,516,638	27,592,580
Accrued interest expense	4,035,955	4,091,458
Other accrued expenses	8,481,486	13,366,179
Estimated third-party settlements	6,956,833	4,014,624
Long-term debt due within one year	5,144,999	4,932,435
Total current liabilities	63,470,635	72,130,290
Other liabilities:		
Long-term debt, less amounts due within one year	284,592,278	289,472,299
Total liabilities	348,062,913	361,602,589
Net position:		
Unrestricted	421,630,522	381,109,710
Net investment in capital assets	119,704,749	124,355,582
Restricted for debt service	27,029,427	26,890,786
Total net position	568,364,698	532,356,078
Total liabilities and net position	$ 916,427,611	$ 893,958,667

West Tennessee Healthcare and Related Affiliates

Statements of Revenues and Expenses and Changes in Net Position

For the Years Ended June 30, 2014 and 2013

	2014	2013
Operating revenues		
Net patient service revenues, net of provision for bad debts of $70,639,945 in 2014 and $67,838,070 in 2013	$ 588,190,053	$ 569,100,039
Other revenues	40,676,644	44,934,457
Total operating revenues	628,866,697	614,034,496
Operating expenses		
Salaries and benefits	327,663,805	319,701,770
Supplies and other	230,027,196	215,015,060
Depreciation and amortization	47,627,135	48,016,258
Total operating expenses	605,318,136	582,733,088
Operating income	23,548,561	31,301,408
Nonoperating revenues (expenses)		
Investment income	31,169,994	16,718,004
Interest expense	(17,248,129)	(17,506,401)
Contribution to City of Jackson and Madison County	(902,604)	(1,231,291)
Contribution to City of Jackson: Sportsplex	(150,000)	(150,000)
Contribution to West Tennessee Healthcare Foundation	(409,202)	(409,702)
Nonoperating revenues (expenses), net	12,460,059	(2,579,390)
Increase in net position	36,008,620	28,722,018
Net position at beginning of year	532,356,078	503,634,060
Net position at end of year	$ 568,364,698	$ 532,356,078

See accompanying notes.

West Tennessee Healthcare and Related Affiliates

Statements of Cash Flows

For the Years Ended June 30, 2014 and 2013

	2014	2013
Operating activities		
Receipts from third-party payors and patients	$ 579,607,617	$ 558,181,398
Receipts from other operations	40,676,644	44,934,455
Payments to suppliers	(229,694,266)	(218,370,237)
Payments to employees	(330,739,749)	(309,564,404)
Net cash provided by operating activities	59,850,246	75,181,212
Noncapital financing activity		
Contributions to City, County, and Foundation	(959,202)	(1,389,752)
Net cash used in noncapital financing activity	(959,202)	(1,389,752)
Investing activities		
Interest, dividends, and realized gain on investments	5,143,351	5,896,890
Net change in restricted assets	5,708,759	(9,772,667)
Net cash provided by (used in) investing activities	10,852,110	(3,875,777)
Capital and related financing activities		
Purchases of capital assets	(47,569,697)	(53,533,055)
Repayment of long-term debt	(4,932,434)	(4,767,565)
Interest paid on long-term debt	(16,446,522)	(16,662,299)
Net cash used in capital and related financing activities	(68,948,653)	(74,962,919)
Increase (decrease) in cash and cash equivalents	794,501	(5,047,236)
Cash and cash equivalents at beginning of year	31,941,021	36,988,257
Cash and cash equivalents at end of year	$ 32,735,522	$ 31,941,021
Reconciliation of operating income to net cash provided by operating activities		
Income from operations	$ 23,548,561	$ 31,301,408
Adjustments to reconcile operating income net cash provided by operating activities:		
Depreciation	47,301,408	47,693,237
Impairment loss	5,946,139	-
Loss on disposals of capital assets	525,121	198,418
Amortization	325,727	323,023
Changes in operating assets and liabilities		
Accounts receivable	(8,584,438)	(11,730,096)
Inventory and prepaid expenses	(546,715)	1,095,142
Other assets	151,159	858,055
Accounts payable and accrued expenses	(11,758,925)	13,356,804
Estimated third-party settlements	2,942,209	(7,914,779)
Net cash provided by operating activities	$ 59,850,246	$ 75,181,212
Supplemental schedule of noncash investing activities		
Change in fair value of investments	$ 26,026,643	$ 10,821,114
Capital contribution to City	$ 502,604	$ 401,241

See accompanying notes.

1. Significant Accounting Policies

Organization and Basis of Presentation

The accompanying financial statements include West Tennessee Healthcare and its related affiliates (hereinafter collectively referred to as the "Company"), all of which are under common control of the Jackson-Madison County General Hospital District (the "District") and have been presented as blended component units ("BCUs") of the Company. We consider Jackson-Madison County General Hospital, Bolivar General Hospital, Camden General Hospital, Gibson General Hospital, Humboldt General Hospital, Milan General Hospital, Pathways Behavioral Health, Medical Center Medical Products, Health Partners, Therapy & Learning Center and the West Tennessee Medical Group BCUs of West Tennessee Healthcare, as the governing body is substantively the same as the governing body of West Tennessee Healthcare and has operational responsibility of those component units. The Company presents its financial statements in accordance with accounting principles generally accepted in the United States of America. All significant intercompany balances and transactions have been eliminated.

Proprietary Fund Accounting

The Company utilizes the economic resources measurement focus and the proprietary fund method of accounting whereby revenues and expenses are recognized on an accrual basis. Substantially all revenues and expenses are subject to accrual.

Reclassifications

Certain reclassifications have been made to the 2013 financial statements to conform with the classifications used in 2014. These reclassifications had no impact on the Company's financial position or results of operations.

Recent Accounting Pronouncements

The Government Accounting Standards Board ("GASB") recently issued Statement No. 68, *Accounting and Financial Reporting for Pensions,* which was approved in June 2012. The standard applies to government employers that offer pension benefits through a pension trust or an equivalent arrangement. It replaces GASB Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers,* and GASB Statement No. 50, *Pension Disclosures,* for these employers. The standard is intended to improve the usefulness of financial statements in assessing accountability and inter-period equity by requiring recognition of the entire net pension liability and a more comprehensive of pension expense, as well as explanatory disclosures in the notes to the financial statements and required supplemental information.

1. Significant Accounting Policies (continued)

Recent Accounting Pronouncements (continued)

Among other requirements under the standard, government employers will have to record a net pension liability in their financial statements for defined benefit plans that is based on fiduciary plan net position rather than plan funding. The new standard is effective for fiscal years beginning after June 15, 2014. The Company is working with its actuarial firm to determine the impact that this standard will have on the Company's financial statements. The impact upon adoption is unknown.

Cash and Cash Equivalents

The Company considers temporary cash investments with a maturity of three months or less when purchased to be cash and cash equivalents.

Investments

The Company's investments are reported at fair value in accordance with GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools.* The Company invests in government bonds, short-term money market investments, equity securities and alternative investments that are in accordance with the Company's investment policy.

Investments include the Company's ownership interest in various limited partnerships and investment funds (collectively referred to as Funds) that, in turn, invest the capital of the Funds in other funds. These Funds have no significant liabilities, and the equity of the Funds is based upon the fair value of the financial instruments held. These Funds invest in real estate, hedge funds, and limited partnerships. The fair value of these investments is determined by the underlying asset's manager or independent appraisals (in the case of real estate). Due to inherent uncertainty of these estimates, these values may differ materially from the values that would have been used had a ready market for these investments existed.

The calculation of realized gains and losses is independent of a calculation of the net change in the fair value of investments. Realized gains and losses on investments that had been held in more than one fiscal year and sold in the current year were included as a change in the fair value of investments reported in the prior year and the current year. Realized and unrealized gains and losses are included in investment income in the accompanying statements of revenues and expenses and changes in net position.

Inventories

Inventories are stated at the lower of cost (first-in, first-out method) or market.

1. Significant Accounting Policies (continued)

Funded Depreciation

The Company reserves funds for future purchases of capital assets. Investment earnings on funded depreciation funds were $1,772,139 and $1,270,106 for the years ended June 30, 2014 and 2013, respectively, and are included in investment income in the accompanying statements of revenues and expenses and changes in net position.

Goodwill and Other Intangible Assets

Intangible assets including goodwill are amortized over their estimated useful lives of 5 to 40 years.

Capital Assets

Property, plant, and equipment are recorded on the basis of cost. Provisions for depreciation are computed by the straight-line method based on the estimated useful lives of the assets.

Deferred Outflows/Inflows of Resources

In addition to assets, the statements of net position will sometimes report a separate section for deferred outflows of resources. This separate financial statement element, deferred outflows of resources, represents a consumption of net position that applies to a future period(s) and so will not be recognized as outflow of resources (expense) until then. In addition to liabilities, the statements of net position will sometimes report a separate section for deferred inflows of resources. This separate financial statement element, deferred inflows of resources, represents an acquisition of net position that applies to a future period(s) and so will not be recognized as an inflow of resources (revenue) until that time.

Compensated Absences

The Company allows employees to accumulate paid time off to be used for vacation, holiday and sick time. The Company allows employees to be paid for their vacation and holiday time not taken and accrues its liability for such time. Such liability is classified as accrued compensation and related expenses in the accompanying statements of net position.

Bond Original Issue Discounts

Bond original issue discounts or premiums are netted against the long-term debt accounts and are amortized over the life of the related bonds by the interest method. Such amortization is included in interest expense in the accompanying statements of revenues and expenses and changes in net position.

1. Significant Accounting Policies (continued)

Patient Accounts Receivable

Patient accounts receivable are reported net of both an estimated allowance for contractual adjustments and an estimated allowance for uncollectible accounts. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, TennCare and other third-party payor programs. The bad debt allowance is estimated based upon the age of the account, prior experience and any unusual circumstances which affect the collectability. The Company does not require collateral or other security for patient accounts receivable and routinely accepts assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans or policies.

Charity Care and Community Benefit

As a community provider, the Company's policy is to accept all patients regardless of their ability to pay. Management believes that substantially all the uncollected amounts are due to patients' inability to pay. Therefore, all amounts which are not collected other than third-party payor contractual adjustments, are recorded as charity care and excluded from net patient service revenues. The community benefit provided through charity care, including provisions for bad debts, was $101,969,577 and $103,852,676, based on gross charges, for the years ended June 30, 2014 and 2013, respectively.

EHR Incentive Payments

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act ("HITECH"). The provisions were designed to increase the use of electronic health record ("EHR") technology and establish the requirements for a Medicare and Medicaid incentive payment program beginning in 2011 for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid incentive payments are available to providers that adopt, implement or upgrade certified EHR technology. Providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional Medicaid incentive payments.

The Company accounts for HITECH incentive payments under a grant accounting model. Income from Medicare and Medicaid incentive payments is recognized ratably as revenue as the Company has demonstrated that it complied with the meaningful use criteria over the applicable compliance period. The Company recognized revenue from Medicare and Medicaid incentive payments after it adopted certified EHR technology. Incentive payments totaling $5,489,937 and $8,076,946 for the years ended June 30, 2014 and 2013, respectively, are included in other revenues in the accompanying statements of revenues and expenses and changes in net position. Income from

1. Significant Accounting Policies (continued)

EHR Incentive Payments (continued)

incentive payments is subject to retrospective adjustment as the incentive payments are calculated using cost report data that is subject to audit. Additionally, the Company's compliance with the meaningful use criteria is subject to audit by the federal government or its designee. Changes to recorded estimates could be significant and are recognized in the period they become known.

Net Patient Service Revenues

Net patient service revenues are reported at the net amounts billed to patients, third-party payors and others for services rendered, including an estimated provision for bad debts and estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as changes in estimated provisions and final settlements are determined. Changes in estimated provisions and final settlements are included in net patient service revenues. For the fiscal year ended June 30, 2014, changes in estimated settlements resulted in an increase to revenues of approximately $2,659,233 compared to an increase of $6,000,236 for the fiscal year ended June 30, 2013.

The Company has agreements with third-party payors that provide for payments to the Company at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

- *Medicare.* Inpatient acute care services and skilled nursing services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. The Company receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid-eligible and other low income patients. The Center for Medicare and Medicaid Services ("CMS") established an outpatient prospective payment system. CMS established groups called ambulatory payment classifications for outpatient procedures. Payments are made based on the group assignment for the service rendered. Additionally, CMS established a prospective payment system for home health services.

- *TennCare.* The Company contracts with managed care organizations to receive reimbursement for providing hospital services to patients covered under the TennCare program. Payment arrangements with these managed care organizations consist primarily of prospectively determined rates per discharge, discounts from established charges or prospectively determined daily rates.

1. Significant Accounting Policies (continued)

Net Patient Service Revenues (continued)

- *Other.* The Company has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The bases for payment to the Company under these agreements include prospectively determined rates per discharge, discounts from established charges or prospectively determined daily rates.

Charges at the Company's established billing rates (gross patient service charges) related to patients covered by Medicare, Medicaid, and TennCare programs were 62% and 63% of gross patient service revenues for the fiscal years ended 2014 and 2013, respectively.

Charges exceeding amounts reimbursed and not included in net patient service revenues were as follows:

	Year Ended June 30	
	2014	2013
Medicare	$ 559,410,645	$ 498,825,224
TennCare	187,593,924	168,725,846
Other	322,223,860	294,256,868
Bad debts	70,639,945	67,838,070
	$ 1,139,868,374	$ 1,029,646,008

Laws and regulations governing the Medicare and TennCare/Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined (in relation to certain government programs, primarily Medicare, this is generally referred to as the "cost report" filing and settlement process). Final determination of amounts earned under prospective payment and cost reimbursement activities is subject to review by appropriate governmental authorities or their agents. Management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under Medicare and Medicaid programs.

Essential access, critical access, Federal Medical Percentage Assistance, and Medicaid Disproportionate Share payments of approximately $7,631,110 and $7,114,381 received from TennCare/Medicaid were included in net revenues during the years ended June 30, 2014 and 2013, respectively.

The Company believes that it is in compliance with all applicable laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and TennCare/Medicaid programs.

1. Significant Accounting Policies (continued)

Operating Revenues

The Company's primary mission is to provide health care services to the citizens of West Tennessee through its acute care and specialty care facilities. Therefore, operating revenues include those generated from direct patient care and sundry revenues related to the operation of the Company's facilities.

Federal Income Taxes

The Internal Revenue Service has determined that all material affiliates comprising the Company are exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code ("IRC"). The District is also exempt from federal income taxes under Section 115 of the IRC. As qualified tax-exempt organizations, each of the tax-exempt affiliates comprising the Company must operate in conformity with the IRC to maintain its tax-exempt status.

2. Restatement of Prior Year's Results Due to New Pronouncements

The Company implemented GASB Statement No. 65, *Items Previously Reported as Assets and Liabilities* for the fiscal year 2014. GASB Statement No. 65 establishes accounting and financial reporting standards that reclassify, as deferred outflows of resources or deferred inflow of resources certain items that were previously reported as assets and liabilities. The Company historically has recognized bond issuance costs as other assets and amortized these costs over the life of the associated debt; however, due to the implementation of GASB Statement No. 65, the Company restated prior periods presented to show the write-off of the total unamortized bond issuance costs and the reversal of amortized costs of $2,096,574 and $113,425, respectively at June 30, 2013, for a total reduction of $1,983,149 in total net position. Additionally, the loss on bond refunding of $5,990,940 at June 30, 2013, was reclassified as a deferred outflow of resources (deferred charges on refundings).

The following table summarizes the effects of the implementation of GASB Statement No. 65 on the Statement of Net Position as of June 30, 2013.

		Adjustments		
	Balance as of June 30, 2013	Deferred Outflows	Bond Issue Costs	Restated Balance June 30, 2013
Total current assets	$ 148,465,258	$ -	$ -	$ 148,465,258
Total non-current assets	741,485,618	-	(1,983,149)	739,502,469
Total assets	889,950,876	-	(1,983,149)	887,967,727
Deferred outflows of resources	-	5,990,940	-	5,990,940
Total assets and deferred outflows	$ 889,950,876	$ 5,990,940	$ (1,983,149)	$ 893,958,667

2. Restatement of Prior Year's Results Due to New Pronouncements (continued)

		Adjustments		
	Balance as of June 30, 2013	Deferred Outflows	Bond Issue Costs	Restated Balance June 30, 2013
Total current liabilities	$ 72,130,290	$ -	$ -	$ 72,130,290
Total non-current liabilities	283,481,359	5,990,940	-	289,472,299
Total liabilities	355,611,649	5,990,940	-	361,602,589
Net position				
Unrestricted	383,092,859	-	(1,983,149)	381,109,710
Net investment in capital assets	124,355,582	-	-	124,355,582
Restricted for debt service	26,890,786	-	-	26,890,786
Total net position	534,339,227	-	(1,983,149)	532,356,078
Total liabilities and net position	$ 889,950,876	$ 5,990,940	$ (1,983,149)	$ 893,958,667

The following table summarizes the effects of the implementation of GASB Statement No. 65 on the Statement of Revenues, Expenses and Changes in Net Position as of June 30, 2013.

		Adjustments		
	Balance as of June 30, 2013	Deferred Outflows	Bond Issue Costs	Restated Balance June 30, 2013
Total operating revenues	$ 614,034,496	$ -	$ -	$ 614,034,496
Total operating expenses	534,716,830	-	-	534,716,830
Depreciation and amortization	48,016,258	-	-	48,016,258
Operating income	31,301,408	-	-	31,301,408
Total non-operating expenses, net	(2,692,815)	-	113,425	(2,579,390)
Change in net position	28,608,593	-	113,425	28,722,018
Total net position – beginning of year	505,730,634	-	(2,096,574)	503,634,060
Total net position – end of year	$ 534,339,227	$ -	$(1,983,149)	$ 532,356,078

3. Restricted Assets

The Company, as authorized by the Board of Trustees, maintains checking accounts necessary for daily operations, deposits for the contingency fund, and deposits and investments for the funded depreciation funds. The bond funds are maintained in accordance with the bond indenture related to the Series 2008 $318,980,000 Hospital Revenue Refunding and Improvement Bonds (see Note 6). The interest fund and bond sinking fund are maintained for the payment of bond principal and interest. A debt service reserve fund is maintained to make up any deficiencies in the interest fund and bond sinking fund. Certain amounts comprising the interest fund, bond sinking fund and debt service reserve fund are included in current portion of restricted assets in the accompanying statements of net position based on debt service requirements during the following fiscal year. The Company first applies restricted resources when expenses are incurred for purposes for which both restricted and unrestricted assets are available.

3. Restricted Assets (continued)

The Company's investments and deposits classified as restricted assets are categorized to give an indication of the level of risk assumed by the Company as of year-end. The Company's investments are reported at fair value in accordance with GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools.* The Company invests in government and corporate bonds, equity securities, alternative investments and short-term money market investments that are in accordance with the Company's investment policy.

A summary of restricted assets follows:

	June 30 2014	2013
Externally restricted by bond indenture agreement – held by bond trustee:		
Cash and short-term investments	$ 27,029,427	$ 26,890,786
Internally designated for capital acquisitions:		
Cash and short-term investments	2,130,164	843,575
Corporate and U.S. agency bond funds	70,339,447	69,008,737
Real estate and mortgage fund	13,945,884	14,416,401
Equity securities	100,647,733	95,007,929
	187,063,228	179,276,642
Other internally designated funds for operations:		
Cash and short-term investments	6,152,293	35,121,750
U.S. government agency obligations	46,492,493	31,277,787
Real estate and mortgage fund	9,217,856	6,534,145
Equity securities	66,525,459	43,061,762
	128,388,101	115,995,444
	342,480,756	322,162,872
Total restricted assets	(5,660,068)	(5,190,102)
Amounts required to meet current obligations	$ 336,820,688	$ 316,972,770

4. Cash and Investments

At June 30, 2014 and 2013, the Company had cash and deposits as follows:

	June 30 2014	2013
Cash on hand	$ 13,300	$ 13,872
Cash insured (FDIC) or collateralized with securities held by the Company	2,000,000	2,250,000
Cash collateralized by securities held by the pledging financial institution's trust department in the Company's name or in the State of Tennessee Collateral Pool	30,722,222	29,677,149
Total	$ 32,735,522	$ 31,941,021

4. Cash and Investments (continued)

The types of securities which are permitted investments for Company funds are established by the Company's Investment Policy in accordance with Tennessee Statutes. All funds of the Company may be invested in obligations of or guaranteed by the United States Government. In addition, certain funds of the Company may be invested in obligations of agencies of the U.S. government; obligations of or guaranteed by the State of Tennessee; collateralized certificates of deposit and repurchase agreements; commercial paper; and other asset classes including fixed income, domestic equities, international equities, and alternative investments.

At June 30, 2014 and 2013, the Company had restricted assets in the amount of $35,311,884 and $35,965,326, respectively, invested in short-term investments, which include U.S. agencies and a sweep account secured by Agency securities held by the Trustee. All investments are carried at fair value.

In accordance with GASB Statement No. 40, *Deposit and Investment Risk Disclosures,* the Company has assessed the Custodial Credit Risk, the Concentration of Credit Risk, Credit Risk, and Interest Rate Risk of its Cash and Investments.

(a) Custodial Credit Risk – The Company's deposits are exposed to custodial credit risk if they are not covered by depository insurance and the deposits are uncollateralized or are collateralized with securities held by the pledging financial institution's trust department or agent but not in the depositor-government's name. The deposit risk is that, in the event of the failure of a depository financial institution, the Company will not be able to recover deposits or will not be able to recover collateral securities that are in the possession of an outside party. The Company's investment securities are exposed to custodial credit risk if the securities are uninsured, are not registered in the name of the Company, and are held by either the counterparty or the counterparty's trust department or agent but not in the Company's name. The investment risk is that, in the event of the failure of the counterparty to a transaction, the Company will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party.

At June 30, 2014 and 2013, the Company's bank balances were not exposed to custodial credit risk since the full amount was covered by FDIC insurance or collateralized by securities held by the pledging financial institution's Trust department in the Company's name or by the State of Tennessee Collateral Pool.

As of June 30, 2014 and 2013, the Company's restricted asset investments were comprised of various short-term investments, trusteed funds, corporate and U.S. agency bond funds, real estate mortgage funds, equity securities and alternative investments. Since the investments are registered in the Company's name, they are not exposed to custodial credit risk. In addition, the Company's investment policy requires that specific qualifications be met in order to represent the Company as a custodian.

4. Cash and Investments (continued)

(b) Concentration of Credit Risk – This is the risk associated with the amount of investments the Company has with any one issuer that exceeds 5% or more of its total investments. Investments issued or explicitly guaranteed by the U.S. government and investments in mutual funds, external investment pools, and other pooled investments are excluded from this requirement. The Company's investment policy states that no equity may represent more than 8% of any individual portfolio manager and that no single purchase shall represent more than 5% of the Company's total equity position.

(c) Credit Risk – GASB Statement No. 40 requires that disclosure be made as to the credit rating of all debt security investments except for obligations of the U.S. government or obligations explicitly guaranteed by the U.S. government. This is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The Company's investment policy provides guidelines for its fund managers and lists specific allowable investments. The policy provides for the utilization of varying styles of managers so that portfolio diversification is maximized and total portfolio efficiency is enhanced.

The credit risk profile of the Company's investments as of June 30, 2014, is as follows:

Investment Type	Balance as of June 30, 2014	Rating AAA	A	A-	NA
Restricted assets:					
Cash and short-term investments	$ 35,311,884	$ 3,538,141	$ -	$ -	$ 31,773,743
Corporate and U.S. agency bond funds	116,831,940	-	53,165,767	41,783,867	21,882,306
Real estate and mortgage fund	23,163,740	-	-	-	23,163,740
Equity securities	167,173,192	-	-	-	167,173,192
Total	342,480,756	3,538,141	53,165,767	41,783,867	243,992,981
Amounts required to meet current obligations	(5,660,068)	-	-	-	(5,660,068)
Total investments	$ 336,820,688	$ 3,538,141	$53,165,767	$ 41,783,867	$ 238,332,913

(d) Interest Rate Risk – This is the risk that changes in interest rates will adversely affect the fair value of an investment. The Company's Investment Policy authorizes a strategic asset allocation that is designed to provide an optimal return over the Company's investment horizon and within the Company's risk tolerance and cash requirements.

4. Cash and Investments (continued)

The distribution of the Company's investments by maturity as of June 30, 2014, is as follows:

Investment Type	Balance as of June 30, 2014	Maturity				
		12 Months or Less	12 to 24 Months	24 to 60 Months	Greater than 60 Months	NA
Restricted assets:						
Cash and short-term investments	$ 35,311,884	$14,012,172	$ -	$ 21,299,713	$ -	$ -
Corporate and U.S. agency bond funds	116,831,940	-	-	116,831,940	-	-
Real estate and mortgage fund	23,163,740	-	-	-	-	23,163,740
Equity securities	167,173,192	-	-	-	-	167,173,192
Total investments	342,480,756	14,012,172	-	138,131,653	-	190,336,932
Amounts required to meet current obligations	(5,660,068)	(5,660,068)	-	-	-	-
Total investments	$ 336,820,688	$ 8,352,104	$ -	$ 138,131,653	$ -	$ 190,336,932

For the years ended June 30, 2014 and 2013, investment income is comprised of the following:

	2014	2013
Interest, dividends, and realized gains on investments	$ 5,143,351	$ 5,896,890
Net increase in fair value of investments	26,026,643	10,821,114
	$ 31,169,994	$ 16,718,004

5. Wellness Center Loan Receivable

During the fiscal year ended June 30, 2012, Jackson-Madison County General Hospital executed a promissory note with the WF Healthy Community Investment Fund, LLC in the amount of $16,872,584 for development of the Wellness Center, known as the LIFT at the Jackson Walk development in downtown Jackson. Such note bears interest at the rate of 4.25% until maturity and is payable quarterly. Beginning January 1, 2019, and continuing until the maturity date of September 30, 2041, Jackson-Madison County General Hospital will make quarterly payments of $384,000, which includes principal and interest.

6. Disaggregation of Payable Balances

Accounts payable at June 30, 2014 and 2013, consisted of the following:

	2014	2013
Due to vendors	$ 12,906,443	$ 16,912,835
Due to patients	980,512	772,874
Other	447,769	447,305
Total accounts payable	$ 14,334,724	$ 18,133,014

Other accrued expenses at June 30, 2014 and 2013, consisted of the following:

	2014	2013
Self-insured professional liability	$ 3,256,671	$ 3,088,195
Self-insured employee health claims liability	3,598,000	7,276,667
Other	1,626,815	3,001,307
Total other accrued expenses	$ 8,481,486	$ 13,366,179

7. Capital Assets

Capital assets activity for the years ended June 30, 2014 and 2013, consisted of the following:

	Balance at June 30, 2013	Additions	Transfers	Reductions	Balance at June 30, 2014
Land	$ 32,263,245	$ 1,479,182	$ -	$ (81,223)	$ 33,661,204
Land improvements	14,621,575	16,992	565,803	(23,983)	15,180,387
Building	287,318,752	822,709	27,616,929	(11,903,577)	303,854,813
Equipment	576,964,980	20,125,968	19,076,300	(6,831,808)	609,335,440
Subtotal	911,168,552	22,244,851	47,259,032	(18,840,591)	962,031,844
CIP	30,390,343	25,124,846	(47,259,032)	(599,308)	7,656,848
Total	941,558,895	47,569,697	-	(19,439,899)	969,688,692
Accumulated depreciation	(549,722,325)	(47,301,408)	-	12,466,036	(584,557,697)
Net capital assets	$ 391,836,570	$ 268,289	$ -	$ (6,973,863)	$ 385,130,995

7. Capital Assets (continued)

	Balance at June 30, 2012	Additions	Transfers	Reductions	Balance at June 30, 2013
Land	$ 31,890,236	$ 343,527	$ 55,473	$ (25,991)	$ 32,263,245
Land improvements	14,685,782	19,500	(8,913)	(74,794)	14,621,575
Building	285,630,837	167,807	1,682,461	(162,353)	287,318,752
Equipment	554,762,648	21,821,639	2,468,490	(2,087,797)	576,964,980
Subtotal	886,969,503	22,352,473	4,197,511	(2,350,935)	911,168,552
CIP	3,808,513	31,180,582	(4,197,511)	(401,241)	30,390,343
Total	890,778,016	53,533,055	-	(2,752,176)	941,558,895
Accumulated depreciation	(504,181,605)	(47,693,237)	-	2,152,517	(549,722,325)
Net capital assets	$ 386,596,411	$ 5,839,818	$ -	$ (599,659)	$391,836,570

The Company recognized a loss in fiscal year 2014 of $5,946,139 due to write-down in value of a building formerly leased to the Jackson Clinic. During the fiscal year, the building became vacant. The amount of the reduction in value relates to portions of the building determined to be unusable through space planning work conducted during the fiscal year. The impairment loss is included in supplies and other expense in the accompanying 2014 statement of revenues and expenses and changes in net position.

Depreciation is computed by applying the straight-line method over the estimated remaining useful lives of buildings and improvements (10 to 40 years) and equipment (4 to 20 years). Assets under capital leases are amortized using the straight-line method over the shorter of the estimated useful life of the assets or life of the lease term, excluding any lease renewal, unless the lease renewals are reasonably assured. Amortization expense related to assets under capital leases is included in depreciation expense. The Company's capitalization threshold is $1,000 and a minimum useful life of 2 years. Depreciation expense totaled $47,301,408 and $47,693,237 during the years ended June 30, 2014 and 2013, respectively.

Construction in progress at June 30, 2014, consists of various projects for additions and renovations to the Company's facilities. The Company has outstanding contracts and other commitments related to the completion of these projects. The Company estimates approximately $3,799,000 in costs to complete these projects.

8. Long-Term Debt and Capital Lease Obligations

Long-term debt consists of the following:

	June 30 2014	2013
Hospital Revenue Bonds, Series 2008	$ 294,054,999	$ 298,950,000
Less unamortized bond discount	(4,317,722)	(4,582,701)
	289,737,277	294,367,299
Capital lease obligation	-	37,435
	289,737,277	294,404,734
Amounts due within one year	(5,144,999)	(4,932,435)
	$ 284,592,278	$ 289,472,299

In August 2008, the District issued $318,980,000 of Series 2008 Hospital Revenue Refunding and Improvement Bonds. With the 2008 fixed rate bond issue, the District has eliminated all auction rate and variable rate debt. A portion of the proceeds was used to refund $78,350,000 of its Series 2003 Auction Rate Hospital Revenue Bonds; $48,725,000 of its Series 2006A Auction Rate Hospital Revenue Bonds; and $143,600,000 of its Series 2006B Variable Demand Rate Hospital Revenue Refunding and Improvement Bonds. A Debt Service Reserve Fund was created under the 2008 indenture. On the date of issuance of the 2008 bonds, $21,299,713 of the proceeds of the 2008 bonds were deposited in the Debt Service Reserve Fund. The remaining proceeds of the Series 2008 Bonds will be used to fund capital improvements of certain facilities of the District.

The District's revenues are pledged as collateral to the Series 2008 Bond Issue. Interest rates range from 3.5% to 5.75% on the Series 2008 bond issue. The Company paid interest of $16,446,522 and $16,662,299 for the years ended June 30, 2014 and 2013, respectively.

Long-term debt activity (excluding unamortized bond discount) for the years ended June 30, 2014 and 2013, consisted of the following:

	Balance at June 30, 2012	Additions	Reductions	Balance at June 30, 2013	Additions	Reductions	Balance at June 30, 2014
Bonds payable	$ 303,630,000	$ -	$ 4,680,000	$ 298,950,000	$ -	$ 4,895,001	$ 294,054,999
Other	124,999	-	87,565	37,434	-	37,434	-
Total long-term debt	$ 303,754,999	$ -	$ 4,767,565	$ 298,987,434	$ -	$ 4,932,435	$ 294,054,999

8. Long-Term Debt and Capital Lease Obligations (continued)

Scheduled principal and interest payments, including capital lease obligations and bonds payable, are as follows:

Fiscal Years Ending June 30:	Principal	Interest	Total
2015	$ 5,144,999	$ 16,152,081	$ 21,297,080
2016	5,390,000	15,909,519	21,299,519
2017	5,665,000	15,630,069	21,295,069
2018	5,940,000	15,359,606	21,299,606
2019	6,245,000	15,051,269	21,296,269
2020–2024	36,505,000	69,979,569	106,484,569
2025–2029	47,320,000	59,163,225	106,483,225
2030–2034	61,710,000	44,776,763	106,486,763
2035–2039	80,950,000	25,536,375	106,486,375
2040-2041	39,185,000	3,411,187	42,596,187
	294,054,999	280,969,663	575,024,662
Unamortized bond discount	(4,317,722)	-	(4,317,722)
Total	$ 289,737,277	$ 280,969,663	$ 570,706,940

9. Leases

The Company leases equipment under various operating leases. Rent expense for all operating leases and office space was approximately $5,320,118 and $4,561,763 for the years ended June 30, 2014 and 2013, respectively. Approximate minimum future rental payments, by year and in the aggregate, under noncancellable operating leases with initial terms of one year or more are as follows at June 30, 2014:

2015	$ 4,583,000
2016	4,208,000
2017	3,506,000
2018	2,863,000
2019	2,849,000
2020-2024	6,620,000
2025-2029	5,579,000
2030-2033	3,906,000
	$ 34,114,000

10. Retirement Plans

The Company maintains and administers a noncontributory defined benefit pension plan (the "Plan"), a defined contribution plan, a supplemental 415(m) plan, and an other post-employment benefits plan. The operation of the Plans is consistent with the laws of Tennessee and the United States federal government.

Defined Benefit Plan

The Plan was discontinued for employees hired after June 30, 2010. The West Tennessee Pension Plan is a single-employer defined benefit pension plan. All employees hired after October 1, 2005 and prior to June 30, 2010, are covered on the fifth anniversary of their date of hire after they have completed at least 1,800 hours of employment per year. The Plan provides retirement, termination, disability, and death benefits to plan members and beneficiaries.

The Company has no legal or plan requirements to fund the Plan. The Company has established a policy of funding the end of the Plan year normal cost plus amortization of the unfunded actuarial accrued liability in level dollar amounts over a 30-year period beginning January 1, 2009, up to fully funding the accrued liability using the Projected Unit Credit Cost Method.

Current year contributions made to the Plan equaled 99% of the annual pension cost. Contributions made to the Plan in 2005 equaled the annual pension cost plus an additional one-time discretionary contribution of $6,300,006. Therefore, the net pension obligation had an ending credit balance of $5,142,601 at June 30, 2014, and $5,224,600 at June 30, 2013.

The annual required contribution ("ARC") for the fiscal year ending June 30, 2014, was determined as part of the actuarial valuation for the Plan year beginning January 1, 2013, and was determined using the Projected Unit Credit Cost Method with amortization of the unfunded actuarial liability over 25 years. The actuarial assumptions included (a) 6.5% post-retirement and 6.5% pre-retirement investment rate of return and (b) a projected salary increase of 3.5% per year. Both (a) and (b) include an inflation component of 2.5%. Prior to January 1, 2009, the actuarial value of assets was equal to the market value of assets reported by First Tennessee Bank and CNA Insurance Company. Effective January 1, 2009, a 5-year smoothing method was adopted prospectively. Investment experience different from expected is recognized on a pro rata basis over a 5-year period. The actuarial value of assets at January 1, 2014, reflects three years of smoothing.

10. Retirement Plans (continued)

The annual pension cost for the fiscal year ending June 30, 2014 and 2013, was calculated as follows:

	2014	2013
Annual required contribution	$ 12,992,015	$ 13,093,111
Interest on beginning of year net pension credit	(339,599)	(370,699)
Adjustment to ARC	421,598	441,797
Annual pension cost ("APC")	$ 13,074,014	$ 13,164,209

The funded status of the defined benefit plan, including three year trend information, was as follows:

Defined Benefit Pension Plan Three-Year Trend Information

Fiscal Year Ending	Annual Pension Cost ("APC")	Percentage of APC Contributed	Net Pension Obligation (Credit)
June 30, 2012	$12,622,215	99%	$(5,295,698)
June 30, 2013	13,164,209	99	(5,224,600)
June 30, 2014	13,074,014	99	(5,142,601)

Schedule of Funding Progress

Actuarial Valuation Date	Actuarial Value of Assets	Actuarial Accrued Liability ("AAL")	Total Unfunded AAL Funding Deficit) ("UAAL")	Funded Ratio	Annual Covered Payroll	UAAL as a Percentage of Covered Payroll
January 1, 2013	$ 184,953,998	$ 249,309,801	$ 64,355,803	74%	$ 152,440,972	42%

Defined Contribution Plan

The Company also maintains a defined contribution plan under Section 403(b) of the IRC which provides for voluntary contributions by employees upon employment and matching contributions by the Company after 90 days of service. Substantially all employees of the Company are eligible and may contribute up to 100% of their compensation, subject to certain IRC limitations. During the fiscal year ended June 30, 2012, upon January 1 or July 1 after the completion of 90 days of credited service, for every 1% the employee invested up to 6%, the Company matched 25% of the employee's contribution. Beginning on January 1, 2013, upon January 1 or July 1 after the completion of 90 days of credited service, for every 1% the employee invested up to 6%, the Company matched 50% of the employee's contribution. The Company recognized expense related to the 403(b) Plan of $3,503,304 in 2014 and $2,769,964 in 2013.

10. Retirement Plans (continued)

Supplemental 415(m) Retirement Plan

In 2005, the Company established a supplemental 415(m) retirement plan (the "415 Plan"). The 415 Plan provides monthly benefits equal to the benefit that cannot be paid from the Plan due to the application of the IRC Section 415 limits. Because the 415 Plan is unfunded, these benefit payments are deemed contributions when paid.

The funded status of the 415 Plan, including three year trend information, was as follows:

Supplemental 415(m) Plan Three-Year Trend Information

Fiscal Year Ending	Annual Pension Cost ("APC")	Percentage of APC Contributed	Net 415 Plan Obligation
June 30, 2012	$85,842	82%	$284,739
June 30, 2013	86,745	81	301,527
June 30, 2014	93,841	75	325,411

Schedule of Funding Progress

Actuarial Valuation Date	Actuarial Value of Assets	Actuarial Accrued Liability (AAL)	Total Unfunded AAL (Funding Deficit) (UAAL)	Funded Ratio	Annual Covered Payroll	UAAL as a Percentage of Covered Payroll
July 1, 2013	$ –	$ 1,069,038	$ 1,069,038	– %	N/A	– %

The ARC for the fiscal year ending June 30, 2014, was determined as part of the actuarial valuation for the Plan year beginning January 1, 2013, and was determined using the Projected Unit Credit Cost Method with amortization of the unfunded actuarial liability over 20 years with 11 years remaining.

Other Post-Employment Benefits ("OPEB")

The Company accounts for OPEBs in accordance with GASB Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions.* The Company provides certain postretirement health insurance benefits to certain retired employees and their beneficiaries.

10. Retirement Plans (continued)

Other Post-Employment Benefits ("OPEB") (continued)

Projections of benefits for financial reporting purposes are based on the terms of the plan and the following actuarial assumptions which were determined as part of the January 1, 2013, actuarial valuation. The Company's ARC is calculated using the Projected Unit Credit actuarial cost method. The unfunded actuarial accrued liability is amortized using a level percentage of pay with a 30-year closed amortization period, of which 23 years remain. The actuarial assumptions included 6.5% post-retirement and 6.5% pre-retirement investment rate of return and a projected salary increase of 3.5% per year.

The funded status of the OPEB Plan, including three year trend information, was as follows:

OPEB Plan Three-Year Trend Information

Fiscal Year Ending	Annual Pension Cost ("APC")	Percentage of APC Contributed	Net OPEB Obligation
June 30, 2012	$937,560	100%	$ -
June 30, 2013	908,366	100	-
June 30, 2014	1,051,428	100	-

The amount contributed by the Company for the fiscal year ended June 30, 2014, was $1,051,428, which consisted of $558,717 plus benefit payments of $492,711 made on behalf of the plan. The balance contributed by the Company for the fiscal year ended June 30, 2013, was $908,366, which consisted of $619,657 plus benefit payments of $288,709 made on behalf of the plan.

Schedule of Funding Progress

Actuarial Valuation Date	Actuarial Value of Assets	Actuarial Accrued Liability (AAL)	Total Unfunded AAL (Funding Deficit) (UAAL)	Funded Ratio	Annual Covered Payroll	UAAL as a Percentage of Covered Payroll
January 1, 2013	$ 3,776,350	$10,716,322	$ 6,939,972	35%	$ 230,246,000	3%

11. Commitments and Contingencies

The Company is exposed to various risks of loss from torts; theft of, damage to and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and employee health, dental and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters.

Settled claims have not exceeded this commercial coverage in any of the three preceding years.

11. Commitments and Contingencies (continued)

Professional Liability

The Company established the contingency fund as a professional liability self-insurance fund in accordance with the Government Tort Liability Act, which restricts the District's exposure to professional liability risks to a pre-determined amount per occurrence.

The District is a "governmental entity" within the meaning of the Tennessee Governmental Tort Liability Act (the "Tort Act"). As such, its maximum liability for state law tort causes of action is $300,000 for bodily injury or death of any one person in accident, occurrence, or act, and $700,000 for bodily injury or death of all persons in any one accident, occurrence, or act. These limits are subject to change by the Tennessee Legislature. Prior to July 1, 2002, the Tennessee Governmental Tort Liability limited local government tort liability to $130,000 for individual injury or death in any one occurrence and $350,000 for injury or death of all persons in any one occurrence.

Investment earnings on contingency fund assets were $126,647 and $160,724 for the years ended June 30, 2014 and 2013, respectively, and are included in investment income in the accompanying statements of revenues and expenses and changes in net assets.

The Company's accrual for self-insured professional liability risks was $3,256,671 and $3,088,195 at June 30, 2014 and 2013, respectively, and was based on asserted claims for occurrences prior to that date. The Company does not accrue for unasserted claims or occurrences. In the opinion of management, any liability for such unasserted claims or occurrences would not materially affect the financial position of the Company.

Workers' Compensation

Under the Tennessee Workers' Compensation Law, governmental entities such as the District need not accept the workers' compensation system, thereby remaining subject to common law liability for work-related injuries and retaining all common law defenses to such claims. The limits of liability under the Tort Act are applicable to such claims. The District has not accepted the workers' compensation system. The Tennessee Supreme Court has ruled this exemption applicable to the District's affiliate nonprofit corporations as well.

11. Commitments and Contingencies (continued)

Employee Health

The Company is self-insured with respect to employee health insurance. Estimates of health insurance claims incurred but unpaid as of June 30, 2014 and 2013, are accrued based on estimates that incorporate the Company's past experience, as well as other considerations including the nature of claims and relevant trends. The Company had accrued a liability for incurred but unpaid claims of approximately $3,598,000 and $7,276,667, as of June 30, 2014 and 2013, respectively, which is included in other accrued expenses in the accompanying statements of net position. The expenses related to claims paid during the years ended June 30, 2014 and 2013, are $39,614,409 and $29,952,116, respectively, and are included in salaries and benefits expense.

The following represents changes in those aggregate liabilities for estimates of health insurance for the years ended June 30:

	2014	2013	2012
Claims payable, beginning of year	$ 7,276,667	$ 10,445,233	$ 9,630,758
Incurred claims expense	39,614,409	29,952,116	32,557,260
Claims payments	(43,293,076)	(33,120,682)	(31,742,785)
Claims payable, end of year	$ 3,598,000	$ 7,276,667	$ 10,445,233

Litigation

The Company is subject to claims and suits which arise in the ordinary course of business. In the opinion of management, reserves for estimated losses on pending legal proceedings are adequate, and the ultimate resolution of any pending legal proceedings will not have a material effect on the Company's financial position.

12. Obligated Group

As disclosed in Note 6, the Company has revenue bonds outstanding that are payable from the operating revenues of certain affiliates of the District (the Obligated Group). Summary financial information for the Obligated Group is as follows:

	June 30	
	2014	2013
Assets		
Current assets	$ 116,592,994	$ 107,572,894
Capital assets	373,961,157	374,618,178
Other assets	339,581,019	317,346,418
	830,135,170	799,537,490
Deferred outflows of resources	5,398,807	5,990,940
Total assets and deferred outflows	$ 835,533,977	$ 805,528,430

12. Obligated Group (continued)

	Year Ended June 30	
	June 30	
	2014	2013
Liabilities		
Current liabilities	$ 10,026,195	$ 33,511,529
Long-term debt	284,592,278	289,472,299
	294,618,473	322,983,828
Net position		
Unrestricted net position	405,351,166	348,516,625
Invested in capital assets, net of related financing	108,534,911	107,137,191
Restricted net position	27,029,427	26,890,786
	540,915,504	482,544,602
Total liabilities and net position	$ 835,533,977	$ 805,528,430

	2014	2013
Net patient service revenues	$ 519,106,002	$ 495,078,713
Other operating revenues	28,259,049	22,875,158
Total revenues	547,365,051	517,953,871
Operating expenses	467,902,705	440,065,630
Depreciation	44,662,211	44,496,928
Total expenses	512,564,916	484,562,558
Operating income	34,800,135	33,391,313
Net nonoperating revenues	26,905,316	12,990,018
Interest expense	(17,248,129)	(17,506,401)
Income before transfers	44,457,322	28,874,930
Transfers	13,913,580	(21,684,788)
Increase in net position	58,370,902	7,190,142
Net position, beginning of year	482,544,602	475,354,460
Net position, end of year	$ 540,915,504	$ 482,544,602
Net cash provided by (used in):		
Operating activities	$ 44,394,644	$ 96,053,745
Noncapital financing activities	12,451,772	(23,475,781)
Capital and related financing activities	(65,058,418)	(72,857,445)
Investing activities	5,185,669	(3,903,609)
Net decrease in cash and cash equivalents	(3,026,333)	(4,183,090)
Cash and cash equivalents, beginning of year	20,142,456	24,325,546
Cash and cash equivalents, end of year	$ 17,116,123	$ 20,142,456

13. Concentrations

The Company purchased approximately 45% and 43% of medical supplies and drugs from two vendors for the years ended June 30, 2014 and 2013, respectively.

14. Blended Component Units

We consider Jackson-Madison County General Hospital, Bolivar General Hospital, Camden General Hospital, Gibson General Hospital, Humboldt General Hospital, Milan General Hospital, Pathways Behavioral Health, Medical Center Medical Products, Health Partners, Therapy & Learning Center and the West Tennessee Medical Group blended component units ("BCUs") of West Tennessee Healthcare, as the governing body is substantively the same as the governing body of West Tennessee Healthcare and has operational responsibility of these component units.

In January 2014, Humboldt General Hospital and Gibson General Hospital ceased operations and those corporations were closed. The assets of those hospitals were transferred to Jackson-Madison County General Hospital.

In the statements that follow, we present condensed combining information for the BCUs mentioned above.

Statements of Net Position

June 30, 2014	Jackson-Madison County General Hospital	Milan General Hospital	Bolivar General Hospital	Camden General Hospital	Pathways Behavioral Health	Medical Center Medical Products	West Tennessee Medical Group	Health Partners	Therapy & Learning Center	Eliminations	Total BCUs
Current assets:											
Cash and cash equivalents	$ 17,116,123	$ 2,229,928	$ 1,408,753	$ 2,016,031	$ 4,095,883	$ -	$ 3,016,433	$ 2,852,371	$ -	$ -	$ 32,735,522
Accounts receivable, net	93,371,716	1,513,504	911,125	861,317	1,443,610	1,447,327	2,290,329	-	336,521	-	102,175,449
Other receivables	6,990,295	(172,809)	(174,636)	722,667	569,942	1,245	316,533	-	387,186	(3,892,159)	4,748,264
Inventories	4,782,002	209,717	177,241	176,767	136,581	679,762	225,848	-	-	-	6,387,918
Prepaid expenses	7,153,657	-	-	-	-	-	-	-	-	-	7,153,657
Restricted assets - current portion	5,660,068	-	-	-	-	-	-	-	-	-	5,660,068
Total current assets	135,073,861	3,780,340	2,322,483	3,776,782	6,246,016	2,128,334	5,849,143	2,852,371	723,707	(3,892,159)	158,860,878
Restricted assets	309,364,777	10,151,685	6,679,460	2,169,825	8,454,941	-	-	-	-	-	336,820,688
Other assets	30,216,243	-	-	-	-	-	-	-	-	-	30,216,243
Capital assets, net	372,560,404	2,495,077	2,905,183	1,058,671	1,889,462	1,400,753	1,161,968	11,641	1,647,836	-	385,130,995
Total assets	847,215,285	16,427,102	11,907,126	7,005,278	16,590,419	3,529,087	7,011,111	2,864,012	2,371,543	(3,892,159)	911,028,804
Deferred outflows of resources	5,398,807	-	-	-	-	-	-	-	-	-	5,398,807
Total assets and deferred outflows of resources	$ 852,614,092	$ 16,427,102	$ 11,907,126	$ 7,005,278	$ 16,590,419	$ 3,529,087	$ 7,011,111	$ 2,864,012	$ 2,371,543	$ (3,892,159)	$ 916,427,611
Current liabilities:											
Accounts payable	$ 13,598,832	$ 92,263	$ 64,798	$ 61,331	$ 77,555	$ 255,841	$ 171,217	$ -	$ 12,887	$ -	$ 14,334,724
Long-term debt due within one year	5,144,999	-	-	-	-	-	-	-	-	-	5,144,999
Accrued compensation and related expenses	23,954,894	170	75	20,804	-	151	540,544	-	-	-	24,516,638
Accrued interest expense	4,035,955	-	-	-	-	-	-	-	-	-	4,035,955
Other accrued expenses	(2,190,165)	(65,220)	(5,429,648)	656,830	1,316,633	(20,609,201)	28,152,070	738,112	9,804,234	(3,892,159)	8,481,486
Estimated third-party settlements	6,444,093	309,055	(186,587)	385,496	2,031	-	2,745	-	-	-	6,956,833
Total current liabilities	50,988,608	336,268	(5,551,362)	1,124,461	1,396,219	(20,353,209)	28,866,576	738,112	9,817,121	(3,892,159)	63,470,635
Other liabilities:											
Long-term debt, less amounts due within one year	284,592,278	-	-	-	-	-	-	-	-	-	284,592,278
Total liabilities	335,580,886	336,268	(5,551,362)	1,124,461	1,396,219	(20,353,209)	28,866,576	738,112	9,817,121	(3,892,159)	348,062,913
Net position:											
Unrestricted	382,869,621	13,595,757	14,553,305	4,822,146	13,304,738	22,481,543	(23,017,433)	2,114,259	(9,093,414)	-	421,630,522
Net investment in capital assets	107,134,158	2,495,077	2,905,183	1,058,671	1,889,462	1,400,753	1,161,968	11,641	1,647,836	-	119,704,749
Restricted for debt service	27,029,427	-	-	-	-	-	-	-	-	-	27,029,427
Total net position	517,033,206	16,090,834	17,458,488	5,880,817	15,194,200	23,882,296	(21,855,465)	2,125,900	(7,445,578)	-	568,364,698
Total liabilities and net position	$ 852,614,092	$ 16,427,102	$ 11,907,126	$ 7,005,278	$ 16,590,419	$ 3,529,087	$ 7,011,111	$ 2,864,012	$ 2,371,543	$ (3,892,159)	$ 916,427,611

Statements of Net Position

June 30, 2013	Jackson-Madison County General Hospital	Humboldt General Hospital	Gibson General Hospital	Milan General Hospital	Bolivar General Hospital	Camden General Hospital	Pathways Behavioral Health	Medical Center Medical Products	West Tennessee Medical Group	Health Partners	Therapy & Learning Center	Eliminations	Total BCUs
Current assets:													
Cash and cash equivalents	$ 20,142,456	$ 864,955	$ 799,117	$ 1,082,099	$ 816,491	$1,108,258	$ 2,322,058	$ -	$ 1,912,407	$2,893,180	$ -	$ -	$ 31,941,021
Accounts receivable, net	76,289,996	923,685	731,422	1,183,903	799,842	854,486	2,262,757	1,576,059	3,029,827	-	313,310	-	87,965,287
Other receivables	11,377,202	1,787,812	1,652,294	1,748,000	1,864,249	631,835	1,029,790	2,793	104,659	-	446,311	(10,270,957)	10,373,988
Inventories	4,156,526	210,510	123,621	173,940	190,562	174,892	129,340	616,097	201,829	-	-	-	5,977,317
Prepaid expenses	7,017,543	-	-	-	-	-	-	-	-	-	-	-	7,017,543
Restricted assets - current portion	5,190,102	-	-	-	-	-	-	-	-	-	-	-	5,190,102
Total current assets	124,173,825	3,786,962	3,306,454	4,187,942	3,671,144	2,769,471	5,743,945	2,194,949	5,248,722	2,893,180	759,621	(10,270,957)	148,465,258
Restricted assets	286,653,288	4,611,381	975,691	9,144,684	6,016,888	1,954,589	7,616,249	-	-	-	-	-	316,972,770
Other assets	30,693,129	-	-	-	-	-	-	-	-	-	-	-	30,693,129
Capital assets, net	373,321,268	4,124,767	1,179,989	2,647,709	2,990,173	1,032,691	2,263,848	1,296,911	1,742,511	15,745	1,220,958	-	391,836,570
Total assets	814,841,510	12,523,110	5,462,134	15,980,335	12,678,205	5,756,751	15,624,042	3,491,860	6,991,233	2,908,925	1,980,579	(10,270,957)	887,967,727
Deferred outflows of resources	5,990,940	-	-	-	-	-	-	-	-	-	-	-	5,990,940
Total assets and deferred outflows of resources	$ 820,832,450	$12,523,110	$5,462,134	$15,980,335	$12,678,205	$5,756,751	$15,624,042	$ 3,491,860	$ 6,991,233	$2,908,925	$1,980,579	$(10,270,957)	$893,958,667
Current liabilities:													
Accounts payable	$ 17,212,358	$ 64,934	$ 45,456	$ 63,824	$ 175,009	$ 60,745	$ 91,077	$ 190,721	$ 218,756	$ -	$ 10,134	$ -	$ 18,133,014
Long-term debt due within one year	4,932,435	-	-	-	-	-	-	-	-	-	-	-	4,932,435
Accrued compensation and related expenses	26,612,940	166	229	(407)	408	20,940	30	-	958,274	-	-	-	27,592,580
Accrued interest expense	4,091,458	-	-	-	-	-	-	-	-	-	-	-	4,091,458
Other accrued expenses	14,486,451	(2,027,506)	2,414,109	1,007,735	(4,852,415)	559,739	637,291	(18,795,879)	21,491,445	642,507	8,073,659	(10,270,957)	13,366,179
Estimated third-party settlements	3,576,928	(271,354)	812,246	(246,048)	(702,457)	442,986	2,323	-	400,000	-	-	-	4,014,624
Total current liabilities	70,912,570	(2,233,760)	3,272,040	825,104	(5,379,455)	1,084,410	730,721	(18,605,158)	23,068,475	642,507	8,083,793	(10,270,957)	72,130,290
Other liabilities:													
Long-term debt, less amounts due within one year	289,472,299	-	-	-	-	-	-	-	-	-	-	-	289,472,299
Total liabilities	360,384,869	(2,233,760)	3,272,040	825,104	(5,379,455)	1,084,410	730,721	(18,605,158)	23,068,475	642,507	8,083,793	(10,270,957)	361,602,589
Net position:													
Unrestricted	327,716,514	10,632,103	1,010,105	12,507,522	15,067,487	3,639,651	12,629,473	20,800,107	(17,819,753)	2,250,673	(7,324,172)	-	381,109,710
Net investment in capital assets	105,840,281	4,124,767	1,179,989	2,647,709	2,990,173	1,032,690	2,263,848	1,296,911	1,742,511	15,745	1,220,958	-	124,355,582
Restricted for debt service	26,890,786	-	-	-	-	-	-	-	-	-	-	-	26,890,786
Total net position	460,447,581	14,756,870	2,190,094	15,155,231	18,057,660	4,672,341	14,893,321	22,097,018	(16,077,242)	2,266,418	(6,103,214)	-	532,356,078
Total liabilities and net position	$ 820,832,450	$12,523,110	$5,462,134	$15,980,335	$12,678,205	$5,756,751	$15,624,042	$ 3,491,860	$ 6,991,233	$2,908,925	$1,980,579	$(10,270,957)	$893,958,667

Statements of Revenues and Expenses and Changes in Net Position

Year Ended June 30, 2014	Jackson-Madison County General Hospital	Humboldt General Hospital	Gibson General Hospital	Bolivar General Hospital	Camden General Hospital	Milan General Hospital	Pathways Behavioral Health	Medical Center Medical Products	West Tennessee Medical Group	Health Partners	Therapy & Learning Center	Total BCUs
Revenue												
Patient service revenues	$ 1,501,769,501	$10,358,069	$ 7,282,247	$22,062,194	$19,151,566	$31,998,089	$ 17,216,338	$31,986,520	$ 79,829,111	$ -	$ 6,404,792	$1,728,058,427
Deductions from revenue	995,022,999	8,000,718	5,661,760	16,853,697	11,355,322	23,591,388	7,328,473	19,627,021	48,252,064	-	4,174,932	1,139,868,374
Net patient service revenues	506,746,502	2,357,351	1,620,487	5,208,497	7,796,244	8,406,701	9,887,865	12,359,499	31,577,047	-	2,229,860	588,190,053
Other operating revenues	28,066,684	102,034	124,070	(11,671)	(92,548)	(23,052)	6,773,457	192,365	1,934,400	1,604,698	2,006,207	40,676,644
Total revenues	534,813,186	2,459,385	1,744,557	5,196,826	7,703,696	8,383,649	16,661,322	12,551,864	33,511,447	1,604,698	4,236,067	628,866,697
Operating expenses												
Salaries	197,261,496	2,269,500	2,283,102	3,866,714	3,862,842	4,511,841	9,821,225	2,120,667	28,553,163	871,466	3,679,810	259,101,826
Benefits	55,335,797	477,971	447,523	818,472	861,006	1,038,592	3,133,975	701,067	4,301,482	287,180	1,158,914	68,561,979
Supplies	115,238,250	381,559	243,984	667,475	656,742	1,345,986	1,672,389	6,705,383	1,938,518	21,068	109,393	128,980,747
Other	89,998,786	417,424	368,315	680,255	1,048,774	981,974	2,120,343	541,259	3,818,128	565,751	505,440	101,046,449
Depreciation and amortization	43,964,002	284,658	128,045	431,192	282,030	574,168	455,921	698,210	678,379	5,655	124,875	47,627,135
Total operating expenses	501,798,331	3,831,112	3,470,969	6,464,108	6,711,394	8,452,561	17,203,853	10,766,586	39,289,670	1,751,120	5,578,432	605,318,136
Operating income	33,014,855	(1,371,727)	(1,726,412)	(1,267,282)	992,302	(68,912)	(542,531)	1,785,278	(5,778,223)	(146,422)	(1,342,365)	23,548,561
Nonoperating revenues (expenses)												
Investment income	28,367,125	53,425	11,330	668,110	216,174	1,004,515	843,410	-	-	5,904	1	31,169,994
Interest expenses	(17,248,129)	-	-	-	-	-	-	-	-	-	-	(17,248,129)
Contributions to City and County	(902,604)	-	-	-	-	-	-	-	-	-	-	(902,604)
Contribution to City: Sportsplex	(150,000)	-	-	-	-	-	-	-	-	-	-	(150,000)
Contribution - Foundation	(409,202)	-	-	-	-	-	-	-	-	-	-	(409,202)
Nonoperating revenues (expenses), net	9,657,190	53,425	11,330	668,110	216,174	1,004,515	843,410	-	-	5,904	1	12,460,059
Change in net position	42,672,045	(1,318,302)	(1,715,082)	(599,172)	1,208,476	935,603	300,879	1,785,278	(5,778,223)	(140,518)	(1,342,364)	36,008,620
Beginning net position	460,447,581	14,756,870	2,190,094	18,057,660	4,672,341	15,155,231	14,893,321	22,097,018	(16,077,242)	2,266,418	(6,103,214)	532,356,078
Ending net position	$ 503,119,626	$13,438,568	$ 475,012	$17,458,488	$ 5,880,817	$16,090,834	$ 15,194,200	$23,882,296	$ (21,855,465)	$ 2,125,900	$ (7,445,578)	$ 568,364,698

Statements of Revenues and Expenses and Changes in Net Position

Year Ended June 30, 2013	Jackson-Madison County General Hospital	Humboldt General Hospital	Gibson General Hospital	Bolivar General Hospital	Camden General Hospital	Milan General Hospital	Pathways Behavioral Health	Medical Center Medical Products	West Tennessee Medical Group	Health Partners	Therapy & Learning Center	Total BCUs
Revenue												
Patient service revenues	$1,364,100,834	$ 18,535,922	$ 16,772,213	$ 21,976,946	$ 18,452,255	$ 26,639,803	$ 17,614,737	$ 31,415,706	$ 77,073,296	$ -	$ 6,164,335	$1,598,746,047
Deductions from revenue	881,014,511	12,161,616	12,194,890	16,878,986	11,718,546	19,357,268	7,163,145	19,423,316	45,619,444	-	4,114,286	1,029,646,008
Net patient service revenues	483,086,323	6,374,306	4,577,323	5,097,960	6,733,709	7,282,535	10,451,592	11,992,390	31,453,852	-	2,050,049	569,100,039
Other operating revenues	22,689,344	2,154,793	2,054,334	2,135,875	847,039	2,089,802	6,727,576	185,814	2,207,354	1,821,731	2,020,795	44,934,457
Total revenues	505,775,667	8,529,099	6,631,657	7,233,835	7,580,748	9,372,337	17,179,168	12,178,204	33,661,206	1,821,731	4,070,844	614,034,496
Operating expenses												
Salaries	191,427,892	4,162,508	4,122,413	4,075,900	4,017,983	4,169,231	10,088,611	2,131,982	28,520,137	958,738	3,612,322	257,287,717
Benefits	49,938,721	822,821	783,454	767,045	798,203	849,181	2,809,358	606,286	3,748,716	282,731	1,007,537	62,414,053
Supplies	111,546,538	772,392	632,448	759,644	771,404	1,190,403	1,692,250	7,035,200	2,138,562	23,016	124,536	126,686,393
Other	76,872,817	735,283	702,110	774,998	1,068,593	949,829	1,986,106	506,195	3,726,916	551,383	454,437	88,328,667
Depreciation and amortization	43,775,055	603,317	287,073	420,493	281,736	616,982	425,930	721,874	800,137	12,131	71,530	48,016,258
Total operating expenses	473,561,023	7,096,321	6,527,498	6,798,080	6,937,919	7,775,626	17,002,255	11,001,537	38,934,468	1,827,999	5,270,362	582,733,088
Operating income	32,214,644	1,432,778	104,159	435,755	642,829	1,596,711	176,913	1,176,667	(5,273,262)	(6,268)	(1,199,518)	31,301,408
Nonoperating revenues (expenses)												
Investment income	14,781,011	290,411	61,511	386,142	124,582	575,905	488,670	-	-	9,764	8	16,718,004
Interest expenses	(17,506,401)	-	-	-	-	-	-	-	-	-	-	(17,506,401)
Contributions to City and County	(1,231,291)	-	-	-	-	-	-	-	-	-	-	(1,231,291)
Contribution to City: Sportsplex	(150,000)	-	-	-	-	-	-	-	-	-	-	(150,000)
Contribution - Foundation	(409,702)	-	-	-	-	-	-	-	-	-	-	(409,702)
Nonoperating revenues (expenses), net	(4,516,383)	290,411	61,511	386,142	124,582	575,905	488,670	-	-	9,764	8	(2,579,390)
Change in net position	27,698,261	1,723,189	165,670	821,897	767,411	2,172,616	665,583	1,176,667	(5,273,262)	3,496	(1,199,510)	28,722,018
Reclass of net position	(21,684,788)	-	-	-	-	-	-	-	15,753,133	-	5,931,655	-
Beginning net position	454,434,108	13,033,681	2,024,424	17,235,763	3,904,930	12,982,615	14,227,738	20,920,351	(26,557,113)	2,262,922	(10,835,359)	503,634,060
Ending net position	$ 460,447,581	$ 14,756,870	$ 2,190,094	$ 18,057,660	$ 4,672,341	$ 15,155,231	$ 14,893,321	$ 22,097,018	$ (16,077,242)	$ 2,266,418	$ (6,103,214)	$ 532,356,078

Condensed Statements of Cash Flows

	Jackson-Madison County General Hospital	Humboldt General Hospital	Gibson General Hospital	Bolivar General Hospital	Camden General Hospital	Milan General Hospital	Pathways Behavioral Health	Medical Center Medical Products	West Tennessee Medical Group	Health Partners	Therapy & Learning Center	Total BCUs
Year Ended June 30, 2014												
Net cash provided by (used in) operating activities	$ 63,113,328	$ (8,901,965)	$ (2,441,886)	$ 932,924	$ 1,214,846	$ 1,571,850	$ 1,850,641	$ 802,053	$ 1,201,862	$ (45,159)	$ 551,752	$ 59,850,246
Net cash provided by (used in) noncapital financing activities	(959,202)	-	-	-	-	-	-	-	-	-	-	(959,202)
Net cash provided by (used in) investing activities	5,185,669	4,664,806	987,020	5,540	939	(2,485)	4,719	-	-	5,902	-	10,852,110
Net cash provided by (used in) capital and related financing activities	(71,230,229)	3,840,109	1,051,944	(346,202)	(308,012)	(421,536)	(81,535)	(802,053)	(97,836)	(1,551)	(551,752)	(68,948,653)
Net change in cash and cash equivalents	(3,890,434)	(397,050)	(402,922)	592,262	907,773	1,147,829	1,773,825	-	1,104,026	(40,808)	-	794,501
Cash and cash equivalents, beginning of period	20,142,456	864,955	799,117	816,491	1,108,258	1,082,099	2,322,058	-	1,912,407	2,893,180	-	31,941,021
Cash and cash equivalents, end of period	$ 16,252,022	$ 467,905	$ 396,195	$ 1,408,753	$ 2,016,031	$ 2,229,928	$ 4,095,883	$ -	$ 3,016,433	$ 2,852,372	$ -	$ 32,735,522

Condensed Statements of Cash Flows

	Jackson-Madison County General Hospital	Humboldt General Hospital	Gibson General Hospital	Bolivar General Hospital	Camden General Hospital	Milan General Hospital	Pathways Behavioral Health	Medical Center Medical Products	West Tennessee Medical Group	Health Partners	Therapy & Learning Center	Total BCUs
Year Ended June 30, 2013												
Net cash provided by (used in) operating activities	$ 93,742,426	$ 121,720	$ 91,478	$ 287,429	$ 83,752	$ 423,204	$ (293,098)	$572,749	$ (14,674,515)	$ 16,311	$(5,190,244)	$ 75,181,212
Net cash provided by (used in) noncapital financing activities	(1,389,752)	-	-	-	-	-	-	-	-	-	-	(1,389,752)
Net cash provided by (used in) investing activities	(1,966,616)	(290,370)	(61,438)	(378,872)	(123,077)	(575,823)	(479,581)	-	-	-	-	(3,875,777)
Net cash provided by (used in) capital and related financing activities	(94,569,148)	(113,956)	(142,663)	(143,916)	(97,451)	(135,854)	(97,229)	(572,749)	15,719,803	-	5,190,244	(74,962,919)
Net change in cash and cash equivalents	(4,183,090)	(282,606)	(112,623)	(235,359)	(136,776)	(288,473)	(869,908)	-	1,045,288	16,311	-	(5,047,236)
Cash and cash equivalents, beginning of period	24,325,546	1,147,561	911,740	1,051,850	1,245,034	1,370,572	3,191,966	-	867,119	2,876,869	-	36,988,257
Cash and cash equivalents, end of period	$ 20,142,456	$ 864,955	$ 799,117	$ 816,491	$ 1,108,258	$ 1,082,099	$ 2,322,058	$ -	$ 1,912,407	$ 2,893,180	$ -	$ 31,941,021

Required Supplementary Information

West Tennessee Healthcare and Related Affiliates

Defined Benefit Retirement Plans
Schedule of Employer Contributions (Unaudited)

Pension Plan[a]

Year Ended December 31	Fiscal Year Ending	Annual Required Contribution	Actual Contribution	Percentage Contributed
2008	June 30, 2009	$ 10,937,013	$ 10,937,016	100%
2009	June 30, 2010	11,068,225	11,068,225	100%
2010	June 30, 2011	11,217,077	11,217,077	100%
2011	June 30, 2012	12,555,768	12,555,768	100%
2012	June 30, 2013	13,093,111	13,093,111	100%
2013	June 30, 2014	12,992,015	12,992,015	100%

Supplemental 415(m) Plan

Year Ended December 31	Fiscal Year Ending	Annual Required Contribution	Actual Contribution	Percentage Contributed
2008	June 30, 2009	$ 91,376	$ 64,127	70%
2009	June 30, 2010	91,623	69,957	76%
2010	June 30, 2011	95,100	69,957	74%
2011	June 30, 2012	98,636	69,957	71%
2012	June 30, 2013	101,825	69,957	69%
2013	June 30, 2014	113,908	69,957	61%

OPEB Plan[a]

Year Ended December 31	Fiscal Year Ending	Annual Required Contribution	Actual Contribution	Percentage Contributed
2008	June 30, 2009	$ 647,040	$ 647,040	100%
2009	June 30, 2010	790,751	790,751	100%
2010	June 30, 2011	826,240	826,240	100%
2011	June 30, 2012	937,560	937,560	100%
2012	June 30, 2013	908,366	908,366	100%
2013	June 30, 2014	1,051,428	1,051,428	100%

[a] The actuarially determined contribution requirements for the Company's fiscal year ended June 30, 2014, are based on actuarial valuations as of January 1, 2013.

West Tennessee Healthcare and Related Affiliates

Defined Benefit Retirement Plans
Schedule of Funding Progress (Unaudited)

Pension Plan

Actuarial Valuation Date	Fiscal Year Ending	Actuarial Value of Assets	Actuarial Accrued Liability ("AAL")	Total Unfunded AAL (Funding Deficit) ("UAAL")	Funded Ratio	Annual Covered Payroll	UAAL As % of Covered Payroll
January 1, 2011	June 30, 2011	$ 178,927,625	$228,607,365	$ 49,679,740	78%	$ 158,948,315	31%
January 1, 2012	June 30, 2012	179,550,974	239,688,164	60,137,190	75%	156,334,613	39%
January 1, 2013	June 30, 2013	184,953,998	249,309,801	64,355,803	74%	152,440,972	42%

Supplemental 415(m) Plan

Actuarial Valuation Date	Fiscal Year Ending	Actuarial Value of Assets	Actuarial Accrued Liability ("AAL")	Total Unfunded AAL (Funding Deficit) ("UAAL")	Funded Ratio	Annual Covered Payroll	UAAL As % of Covered Payroll
July 1, 2011	June 30, 2011	$ -	$ 916,816	$ 916,816	0%	NA	NA
July 1, 2012	June 30, 2012	-	901,427	901,427	0%	NA	NA
July 1, 2013	June 30, 2013	-	1,069,038	1,069,038	0%	NA	NA

OPEB Plan

Actuarial Valuation Date	Fiscal Year Ending	Actuarial Value of Assets	Actuarial Accrued Liability ("AAL")	Total Unfunded AAL (Funding Deficit) ("UAAL")	Funded Ratio	Annual Covered Payroll	UAAL As % of Covered Payroll
January 1, 2011	June 30, 2011	$ 2,300,633	$ 8,972,682	$ 6,672,049	26%	NA	NA
January 1, 2012	June 30, 2012	2,930,198	9,251,573	6,321,375	32%	$ 231,463,066	3%
January 1, 2013	June 30, 2013	3,776,350	10,716,322	6,939,972	35%	230,246,194	3%

Supplementary Information

West Tennessee Healthcare and Related Affiliates

Deductions from Gross Patient Service Revenues

For the Year Ended June 30, 2014

	Jackson-Madison County General Hospital	Humboldt General Hospital	Gibson General Hospital	Bolivar General Hospital	Camden General Hospital	Milan General Hospital	Pathways Behavioral Health	Medical Center Medical Products	West Tennessee Medical Group	Health Partners	Therapy & Learning Center	Total BCUs
Medicare	$ 503,223,414	$ 2,845,810	$ 2,200,395	$ 5,029,509	$ 4,546,433	$ 10,313,981	$ 1,153,946	$ 5,531,385	$ 24,565,772	$ -	$ -	$ 559,410,645
Tenncare	150,713,682	2,102,160	1,406,571	4,607,775	2,593,286	4,820,354	2,576,801	7,515,621	9,253,935	-	2,003,739	187,593,924
Other revenue deductions	285,004,140	959,097	697,282	4,552,248	2,020,595	6,563,999	3,376,399	5,191,220	11,711,340	-	2,147,540	322,223,860
Bad debt	56,081,763	2,093,651	1,357,512	2,664,165	2,195,008	1,893,054	221,327	1,388,795	2,721,017		23,653	70,639,945
	$ 995,022,999	$ 8,000,718	$ 5,661,760	$ 16,853,697	$ 11,355,322	$ 23,591,388	$ 7,328,473	$ 19,627,021	$ 48,252,064	$ -	$ 4,174,932	$ 1,139,868,374

West Tennessee Healthcare and Related Affiliates

Deductions from Gross Patient Service Revenues

For the Year Ended June 30, 2013

	Jackson-Madison County General Hospital	Humboldt General Hospital	Gibson General Hospital	Bolivar General Hospital	Camden General Hospital	Milan General Hospital	Pathways Behavioral Health	Medical Center Medical Products	West Tennessee Medical Group	Health Partners	Therapy & Learning Center	Total BCUs
Medicare	$ 442,956,662	$ 3,608,465	$ 5,012,472	$ 5,027,155	$ 3,993,349	$ 8,153,541	$ 885,849	$ 5,448,575	$ 23,739,156	$ -	$ -	$ 498,825,224
Tenncare	129,724,991	3,684,080	2,948,429	4,820,995	2,686,606	4,305,520	2,965,766	6,415,875	8,685,988	-	2,487,596	168,725,846
Other revenue deductions	254,882,339	2,290,998	2,337,837	4,297,337	2,598,969	4,655,859	2,905,881	6,020,357	12,687,103	-	1,580,188	294,256,868
Bad debt	53,450,520	2,578,073	1,896,151	2,733,499	2,439,622	2,242,348	405,649	1,538,508	507,196		46,504	67,838,070
	$ 881,014,512	$ 12,161,616	$ 12,194,889	$ 16,878,986	$ 11,718,546	$ 19,357,268	$ 7,163,145	$ 19,423,315	$ 45,619,443	$ -	$ 4,114,288	$ 1,029,646,008

Independent Auditors' Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Board of Trustees
West Tennessee Healthcare and Related Affiliates

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of West Tennessee Healthcare and Related Affiliates (the "Company"), which comprise the statement of net position as of June 30, 2014, and the related statements of revenues and expenses, and changes in net position, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated October 24, 2014.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Company's internal control over financial reporting ("internal control") to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we do not express and opinion on the effectiveness of the Company's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

999 South Shady Grove Road, Suite 400, Memphis, TN 38120 | T 901.761.3000 | F 901.761.9667 | dhgllp.com

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Company's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Company's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Company's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Dixon Hughes Goodman LLP

October 24, 2014

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

December 1, 2015

Vicki Lake
Jackson-Madison County General Hospital
620 Skyline Dr
Jackson, TN 38301

RE: Certificate of Need Application -- West Tennessee Rehabilitation Center - CN1510-044
The establishment of a 48 bed rehabilitation hospital to be constructed on a 5.58 acre site adjacent to the main hospital campus of Jackson-Madison County General Hospital. As part of the project, the proposed facility will be jointly owned by Jackson Madison General Hospital and Health South Corporation with management by Health South. Jackson-Madison General Hospital will delicense its 48 inpatient rehabilitation beds. The estimated project cost is $28,276,777.

Dear Ms. Lake:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on October 1, 2015. The first sixty (60) days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the sixty (60) day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review within the thirty (30)-day period immediately following. You will receive a copy of their findings. The Health Services and Development Agency will review your application on February 24, 2016.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill/MF

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill MMH/MF
Executive Director

DATE: December 1, 2015

RE: Certificate of Need Application
West Tennessee Rehabilitation Center - CN1510-044

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on December 1, 2015 and end on February 1, 2016.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Vicki Lake

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the The Jackson Sun (Name of Newspaper) which is a newspaper of general circulation in Madison (County), Tennessee, on or before October 10 (Month / day), 20 15 (Year) for one day.

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: West Tennessee Rehabilitation Center (Name of Applicant) (Facility Type-Existing)

owned by: West Tennessee Rehabilitation Hospital, LLC with an ownership type of limited liability company and to be managed by: HealthSouth Corporation intends to file an application for a Certificate of Need for [PROJECT DESCRIPTION BEGINS HERE]:

establishing a 48 bed inpatient rehabilitation hospital at 616 West Forest Avenue, Jackson, Tennessee. The project will require approximately 59,450 square feet of new construction, and the estimated cost of the project is $34,329,180. The project will not involve the purchase of major medical equipment. The applicant is jointly owned by the Jackson-Madison County General Hospital District and HealthSouth Corporation. Upon completion of the project, Jackson-Madison County General Hospital will delicense its 48 inpatient rehabiltiation beds.

The anticipated date of filing the application is: October 14, 20 15

The contact person for this project is Victoria S. Lake (Contact Name), Director (Title)

who may be reached at: Jackson-Madison County General Hospital (Company Name), 620 Skyline Drive (Address)

Jackson (City), TN (State), 38301 (Zip Code), (731) 984-2160 (Area Code / Phone Number)

Victoria S. Lake (Signature), 10/08/15 (Date), Vicki.Lake@WTH.org (E-mail Address)

==========

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

==========

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

Supplemental #1
-ORIGINAL-

West Tennessee Rehabilitation Center

CN1510-044

West Tennessee Healthcare

620 Skyline Drive • Jackson, Tennessee 38301 • 731-541-5000 • www.wth.org

October 27, 2015

Mr. Jeff Grimm
HSD Examiner
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th floor
Nashville, Tennessee 37243

RE: Certificate of Need Application CN1510-044
West Tennessee Rehabilitation Center – Establishment of a 48 Bed Freestanding Rehabilitation Hospital-Responses

Dear Mr Grimm:

We are in receipt of your questions for items that need clarification or additional information. Below please find our responses.

---

1. **Section A, Applicant Profile, Item 3**
Registration with the Tennessee Secretary of State by the applicant LLC, a Delaware Corporation formed on October 8, 2015, is noted. The referenced organizational chart for Jackson-Madison County General Hospital and identification of the facilities owned by HealthSouth Corporation in Attachment 4 appears to be missing from the application. Please provide the attachment. ***Note: For the facilities operated by HealthSouth in Tennessee, please include the names & addresses of the facilities, number of licensed beds and date of original license issued by the Tennessee Department of Health.***

Response: Exhibit 1 contains an organizational chart for West Tennessee Healthcare that includes the structure of Jackson-Madison County General Hospital. Exhibit 1 also contains a chart depicting the HealthSouth Tennessee Facilities as of October 23, 2015. Below are the street address and the number of beds for each facility.

HealthSouth Rehabilitation Hospital (Kingsport) – 113 Cassell Drive, Kingsport, 37660, 50 beds
HealthSouth Rehabilitation Hospital of Memphis – 1282 Union Avenue, Memphis, 38104, 80 beds
HealthSouth Rehabilitation Hospital-North Memphis – 4100 Austin Peay Highway, Memphis, 38128, 50 beds
Quillen Rehabilitation Hospital – 2511 Wesley Street, Johnson City, 37601, 26 beds
HealthSouth Chattanooga Rehabilitation Hospital- 2412 McCallie Avenue, Chattanooga, 37404, 69 beds
Health South Cane Creek Rehabilitation Hospital – 180 Mount Pelia Road, Martin, 38237, 40 beds
Vanderbilt Stallworth Rehabilitation Hospital – 2201 Children's Way, Nashville, 37212, 80 beds

2. **Section A, Applicant Profile, Item 6**
The copy of the unsigned ground lease for the 5.59 acre site planned for the construction of the proposed 48-bed rehabilitation hospital located at 616 West Forest Avenue in Jackson is noted. Please provide a title or deed documenting current ownership by West Tennessee HealthCare, Inc. of the site.

Please also provide a fully executed/signed and dated option to lease or similar document between West Tennessee HealthCare, Inc. and the applicant LLC confirming the applicant's legal interest in the site. The document should identify the term and estimated lease cost of the agreement and must be valid on the date of the hearing of the application.

Please provide the distance of the proposed site from the current 48 bed rehabilitation unit located on the campus of the hospital.

Response:
Exhibit 2 contains the Warranty Deed, which is provided to show ownership by West Tennessee Healthcare of the proposed site for the West Tennessee Rehabilitation Center.

Exhibit 2 also contains a fully executed/signed and dated option to lease between West Tennessee Healthcare and West Tennessee Rehabilitation Hospital LLC.

The distance from the main entrance of Jackson-Madison County General Hospital at 620 Skyline Drive to the proposed site of the West Tennessee Rehabilitation Center at 616 West Forest Avenue is .7 mile.

The distance from Patient Discharge of Jackson-Madison County General Hospital at 708 West Forest Avenue to the proposed site of the West Tennessee Rehabilitation Center at 616 West Forest Avenue is .2 mile.

SUPPLEMENTAL #1
October 29, 2015
10:16 am

3. **Section A, Item 9**
The bed complement for the proposed freestanding rehabilitation hospital is noted. Based on the advisement, with letter from the Chief Executive Officer of Jackson-Madison County General Hospital, that the hospital has committed to the delicense of its 48-bed rehabilitation unit as a part of this project, please also provide the bed complement for the hospital.

Response: A completed bed complement chart for Jackson-Madison County General Hospital is found in Exhibit 3.

4. **Section B, Project Description, Item II. A.**
If this project were approved and a CON application was subsequently filed for additional beds at a later date, based on the design of the proposed facility, how disruptive would future expansion be to the operations of the facility?

Response: The design of the proposed facility provides shell space at the end of a corridor that allows for a 10-bed future addition. All construction activities will be separated from patient care operations through the construction of a partition to physically separate the two spaces. No programs or activities will be disrupted if new patient rooms are constructed.

It appears that the useable square feet (SF) in the referenced square footage chart is 48,255 SF in lieu of the 53,330 SF identified in the October 9, 2015 letter from Mr. Frederick, AIA, of Frederick & Associates Architects, Inc. of Sarasota, Florida. Please explain the reason(s) for the difference.

Response The 48,255 SF number is the net square footage of the floor plan and excludes walls and hallways. Please note that Mr. Frederick's letter listing 53,350 SF is for the entire facility, while the square footage table includes 6,120 SF for the potential bed addition. See Exhibit 4 for a depiction of the space.

5. **Section B, Project Description, Item II.C.**
The applicant notes the reply is not applicable since the hospital owner is an existing provider of comprehensive inpatient rehabilitation services. This appears to conflict with ownership of the proposed freestanding rehabilitation facility by West Tennessee Rehabilitation Hospital, LLC per the response to Item 3 (with attachments) provided in the application. Please clarify.

If in error, please check Item 20 and submit a replacement page labeled 10-R for the application.

Response: Replacement page 10-R is attached as Exhibit 5.

6. **Section B, Project Description, Item II.D.**
The benefits of the proposed freestanding rehab facility facilitated, in part, by the de-licensure of the hospital's 48-bed rehab unit are noted. With respect to the existing hospital unit, please provide examples of plans for the use of the vacated 48-bed unit.

Response: The space that will be vacated by the West Tennessee Rehabilitation Center Rehab on the C tower of Jackson-Madison County General Hospital will be used for patient rooms. Currently we are in the process of evaluating the patient rooms and nursing floors of the B tower of Jackson-Madison County General Hospital. The goal of this plan is to design and renovate these nursing floors to provide larger patient rooms. The space vacated by the West Tennessee Rehabilitation Center can be used to recapture beds that were lost when other patient rooms are enlarged.

7. **Section B, Project Description, Items III (Plot Plan) and IV (Floor Plan)**
Plot Plan- it would be helpful to include a Google map or similar visual to show the proximity of the proposed facility to the hospital campus in Jackson.

Response: Exhibit 6 contains a picture of the campus indicating the proposed West Tennessee Rehabilitation Center at 616 West Forest Avenue and the Jackson-Madison County General Hospital at 620 Skyline Drive.

Floor Plan -The labels on the floor plan of the proposed facility are too small to be legible. As an example, the locations of the main dining area, therapy, lobby and recreation areas cannot be readily identified. Please enlarge and provide a replacement floor plan.

Response: Exhibit 7 contains a replacement floor plan for the West Tennessee Rehabilitation Center.

What is the AIA recommended patient room size for the facility and how does it compare to minimum requirements for State, Medicare, and accreditation organizations such as the Joint Commission?

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Response: The Guidelines for Design and Construction of Hospital and Outpatient Facilities state that the minimum size of a single patient room is 140 SF of clear floor area. The single patient rooms in the proposed project have a clear square foot area of 148 SF.

8. **Section C. Need, Item 1 (Specific Criteria- Comprehensive Inpatient Rehabilitation Services) Standards 2 and 6**
Standard 2 – In addition to the table showing population by county, please complete the table below.

Service Area Bed Need, 2019 Projected

County	Current Certified Rehab Beds 2015	2019 Rehab Bed Need	Net Need/ (Surplus)
Primary Service Area Counties Madison Carroll Chester Crockett Gibson Hardeman Haywood Henderson	48	25	(23)
Secondary Service Area Counties Benton Decatur Dyer Hardin Henry Lauderdale McNairy Obion Weakley County	40	29	(11)
Total	88	54	(34)

Standard 6 – Please complete the table below showing the licensed bed occupancy of the licensed rehab beds in the service area for the most recent 3 year period.

Service Area Inpatient Rehabilitation Bed Patient Day Trend

Hospital	Current Licensed Beds	2012	2013	2014	% Change '12-'14	Licensed Bed Occupancy 2014
Jackson Madison County General Hospital	48	9,232	12,176	13,560	46.9%	77.4%
Health South Cane Creek	40	10,428	9,717	9,375	-10.1%	64.2%
TOTAL	88	19,660	21,893	22,935	16.7%	71.4%

9. **Section C. Need, Item 1 (Specific Criteria- Comprehensive Inpatient Rehabilitation Services) Standard 7**
Please describe plans for the proposed facility's physician medical staff and provide a resume for the medical director referenced in the response. Please also describe in more detail HealthSouth's experience with recruiting physiatrists and other related physician specialties.

Response: HealthSouth puts forth special efforts to attract quality staff for its rehabilitation programs, including physiatrists and other related physician specialties, and has initiated a number of innovative approaches to recruit and retain staff. Some of the traditional methods of recruiting include advertising in colleges that offer specialty programs, clinical affiliation programs with universities in allied health fields, and participation in professional conferences and educational events. Besides the traditional recruiting methods, HealthSouth maintains residency programs with several schools of allied health and maintains affiliations with health professional education programs, including medical schools. HealthSouth has active national affiliation agreements with more than 450 universities and colleges and a network of academic affiliations that helps to provide clinical experience to the next generation of medical staff. Exhibit 8 contains the resume of the medical director, Dr. Davidson Curwen.

SUPPLEMENTAL #1
October 29, 2015
10:16 am

10. Section C, Need, Item 2

The response is noted. During the development of the project, was any consideration given to operating the proposed 48-bed freestanding rehabilitation facility under the license of Jackson-Madison County General Hospital and contracting with the applicant LLC for operation of the facility? Please clarify by discussing the pros/cons of this option compared to the plan presented in the Certificate of Need application.

Response: Yes. The decision to enter into a joint venture with HealthSouth was the culmination of a period of evaluating options and proposals from different companies. From a business perspective, compared with a management model, the joint venture model will provide more risk and benefit sharing for both parties. The model will give the partners more stake in the operation of the unit for the long-term by sharing ownership. West Tennessee Healthcare feels that this model is superior to the management model in achieving financial sustainability and high quality performance.

11. Section C, Need, Item 3 (Service Area)

The table showing patient origin for the hospital is noted. Per the response to Item 3 of the project specific criteria on page 14, please also complete the table below showing patient origin by county for West Tennessee Rehabilitation Center patients and Jackson Madison County General Hospital patients during the most recent 12-month period.

County	*Rehab Patient Days*	*as a % of Total Rehab Days*	*Total Hospital Patient Days*	*as a % of Total Hospital Days*
Primary Service Area Counties				
Madison	*4,916*	*36.3%*	*45,756*	*10.7%*
Carroll	*646*	*4.8%*	*8,970*	*7.2%*
Chester	*454*	*3.4%*	*6,052*	*7.5%*
Crockett	*593*	*4.4%*	*6,338*	*9.4%*
Gibson	*1,586*	*11.7%*	*24,171*	*6.6%*
Hardeman	*852*	*6.3%*	*9,378*	*9.0%*
Haywood	*549*	*4.1%*	*7,102*	*7.7%*
Henderson	*661*	*4.9%*	*8,846*	*7.5%*
Secondary Service Area Counties				
Benton	*240*	*1.8%*	*3,346*	*7.2%*
Decatur	*346*	*2.6%*	*4,481*	*7.7%*
Dyer	*514*	*3.8%*	*7,114*	*7.2%*

Hardin	*399*	*2.9%*	*4,869*	*8.2%*
Henry	*158*	*1.2%*	*3,215*	*5.0%*
Lauderdale	*239*	*1.8%*	*4,694*	*5.1%*
McNairy	*507*	*3.7%*	*7,547*	*6.7%*
Obion	*212*	*1.6%*	*3,659*	*5.8%*
Weakley	*265*	*2.0%*	*4,279*	*6.2%*
Service Area Total	*13,137*		*159,817*	*8.2%*
Other TN Counties	*278*	*2.1%*	*3,525*	*7.9%*
Other State Counties	*119*	*0.9%*	*1,988*	*6.0%*
Total	*13,534*	*100.0%*	*165,330*	*8.2%*

12. *Section C. Need Item 5*

The response identifying certified inpatient rehab beds in the primary and secondary service area is noted. Please complete the table below showing utilization of HealthSouth Cane Creek Hospital to complement the utilization provided for West Tennessee Rehabilitation Center in Section C, Need, Item 6.

Year	*Licensed Beds*	*Staffed Beds*	*Licensed Bed Occupancy*	*Discharges*	*Average Daily Census*
2012	*40*	*40*	*71.4%*	*809*	*28.6*
2013	*40*	*40*	*66.7%*	*784*	*26.6*
2014	*40*	*40*	*64.2%*	*735*	*25.7*

13. *Section C. Need Item 6*

Please add licensed bed occupancy to the historical and projected utilization provided for this item in the application.

Response: See above response.

***Of the thirteen specific diagnoses defined by CMS as part of the "60 Percent Rule", including Stroke; Spinal Cord Injury; Amputation; Major Multiple Trauma; Fracture of the Femur (hip fracture); Brain Injury; Neurological Disorders; Burns; Active Polyarticular Rheumatoid Arthritis; Congenital Deformities; Systemic Vasculidities; Severe or Advanced Osteoarthritis; Hip and Knee Replacements accompanied by extreme obesity with a body mass index of at least 50, or be 85 years of age or older, which ones will apply to the proposed free*standing rehabilitation hospital? Please provide the projection numbers for each of the anticipated diagnoses and the methodology used to reach the projection numbers.

Response: The proposed facility expects to treat all types of patients covered under the CMS-13 diagnosis codes. While exact numbers may vary, estimates may be obtained by comparing the expected number of 2018 discharges (1,115) to the percentage breakdown by category using the latest data for HealthSouth Corporation. These percentages were taken from the HealthSouth Investor Reference Book updated on September 2, 2015. The percentages are from the second quarter of 2015.

	HealthSouth Average Q2—2015	2018 Estimated Cases
Neurological	21.1%	235
Stroke	17.1%	191
Debility	9.7%	108
Other Orthopedic	9.1%	101
Brain Injury	8.9%	99
Fracture Lower Extremity	8.8%	98
Knee/Hip Replacement	6.2%	69
Major Multiple Trauma	4.5%	50
Cardiac	4.3%	48
All Other	10.3%	115

As noted, the project will not increase or decrease certified rehabilitation beds in the service area. However, it appears that utilization of the 48 beds shown by the applicant in the response increased during the 3-year period by approximately 11%. What factors account for the lower rate of increase in Year 1 (2017) of the project (3.8% increase from utilization in 2015)? Are the utilization projections for the proposed freestanding rehabilitation hospital understated? Please clarify. In your response, please describe the details regarding the methodology used to project utilization.

Response: It is anticipated that the Average Length of Stay (ALOS) will decrease from 13.1 to 12.6. We anticipated a conservative, yet steady, ramp up of utilization as noted with discharges increasing 7.4% (1,038 to 1,115) and discharge days increasing only 3.85 (13,560 to 14,080). The decrease in the ALOS accounts for the difference and the slower increase in discharge days when comparing historical operations to projected.

14. **Section C, Economic Feasibility, Item 1**
The Project Costs Chart is noted. As noted previously, the cost of the 35-year ground appears to be omitted from the unsigned copy of the lease. While a fully executed ground lease may not be warranted at present, at a minimum, HSDA will need a signed Option to Lease or similar document that includes the term and lease cost.

Response: Exhibit 2 contains an option to lease.

Please list all fixed and moveable equipment at a cost of $50,000 or greater.

Response: There are two items of fixed and moveable equipment that cost over $50,000. The first is the nurse's call station, which will cost $325,000. The other is the Biodex Overhead Track System with Lift, which will cost $130,000.

15. **Section C, Economic Feasibility, Item 4 (Historical and Projected Data Charts)**
Historical Data Chart – Please provide a Historical Data Chart for Jackson-Madison County General Hospital.

Response: A Historical Data Chart for Jackson-Madison County General Hospital is provided in Exhibit 9.

Please describe what services are included in outpatient gross operating revenue as shown in the chart for the hospital's 48-bed rehabilitation unit. Are revenues for this type of service actually allocated to the rehabilitation department or the hospital as a whole? If related, what is the historical utilization for outpatient services during the 3 fiscal year periods? Please clarify.

Response: Services included in outpatient gross operating revenue are outpatient neuropsychological testing/therapy. These services are provided mainly to outpatients, but can also be provided to inpatients if needed. Services are currently provided by employed Neuropsychologist. Revenues for these services are actually allocated to the West Tennessee Rehabilitation Center. The billable units of service for the three fiscal year periods are as follows:

FY2013	1,441
FY2014	1,449
FY2015	1,689

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Please explain what is included in Line D.8 (b)-Fees to Non-Affiliates- and the factors that resulted in a 39.8% increase in this expense category from Fiscal Year (FY) 2013 to FY2015.

Response: The fees to Non-Affiliates is composed of the management fees paid to REHABCARE GROUP, INC. for management of the West Tennessee Rehabilitation Center during FY 2013 to FY2015. The fees were based on a per discharge rate and included in the management agreement were terms of annual increases in the per discharge rate. Discharges increased from FY213 to FY2015 as follows:

FY2013	759 per discharge rate	$1,070.00
FY2014	918 per discharge rate	$1,103.17
FY2015	1,020 per discharge rate	$1,127.44

Projected Data Chart – Please explain why outpatient revenue was not budgeted for the project.

Response: Revenue for these services have been added to the Projected Data Chart. It is still undecided exactly how these services will be provided, whether as part of Joint Venture, or if the Joint Venture will contract for these services as needed. Until decision is made, we will include in projected numbers. Exhibit 10 contains a revised Projected Data Chart.

Review of the draft management agreement revealed a management fee of 5% of Net Revenue realized by the owner from the operation of the hospital. Based on projected Net Revenue of $16,573,113, HSDA staff calculated this amount at approximately $828,656 in Year 1 of the project (2017) in lieu of the $1,362,667 fee shown in Line D.8 (a) of the Projected Data Chart. Please clarify.

Response: The Management Fee expense for Year 1 of the project (2018) includes 5% of Net Revenue for the management fee plus the development fee for constructing the hospital (approximately $528,000).

16. **Section C, Economic Feasibility, Item 6.B.**
The comparison to HealthSouth Cane Creek's average gross charge in 2013 is noted. Please also compare your average gross charge to the current Medicare allowable charges that apply to the types of patients the proposed facility will serve.

Response: For FY2014, the average charge per patient day for Medicare patients treated West Tennessee Rehabilitation Center was $1,633. The estimated FY2018 overall average charge per patient day is $1,804 per patient day. Overall, that represents a 10.5% increase, or 2.5% annually.

17. **Section C, Economic Feasibility, Item 8**
Based on the joint venture that involves a 50% revenue/profit sharing arrangement with HealthSouth for the proposed freestanding rehabilitation hospital, what is the potential financial impact (loss) to Jackson-Madison County General Hospital as a result of same? Please clarify.

Response: In addition to the proposed new facility in Jackson, the joint venture includes an existing facility currently wholly-owned by HealthSouth in Martin. The combined income for West Tennessee Healthcare from the joint operation is projected to replace and exceed baseline/existing net income for the West Tennessee Rehab Center by year three of operation, using conservative estimates of volume and allowing for ramp-up of the new operation. By using this model, West Tennessee Healthcare will be able to replace the physical facility for the West Tennessee Rehab Center without impacting its net income significantly.

18. **Section C, Economic Feasibility, Item 9**
The Medicare and TennCare/Medicaid payor mix is noted. Please also complete the table below.

Applicant's Projected Payor Source, Year 1

Payor Source	Gross Revenue	as a % of Total	Average Gross Charge/Patient Day
Medicare	$22,211,405	75.0%	$2,097.00
Tenncare	658,613	2.2%	$2,466.72
Managed Care	*		
Commercial	4,924,015	16.6%	$2,074.14
Self-Pay	1,825,372	6.2%	$2,155.10
Other	**		
Total Gross Revenue	$29,619,405	100.0%	

*Managed Care figure combined with Commercial.
**Other figure combined with Self-Pay.

Please provide the most recent payor mix available of some other freestanding rehabilitation hospitals in Tennessee.

Response:

Baptist Rehabilitation-Germantown	Discharges	Inpatient Days	% of Total Based on Discharges
Self-Pay	8	138	1.0%
Commercial	134	1,730	21.8%
Medicaid/Tenncare	9	145	1.0%
Medicare	451	6,056	73.5%
Workers Comp	12	207	2.7%
Other	0	0	0.0%
Total	614	8,276	100.0%

Source: Tennessee Department of Health. Joint Annual Report of Hospitals, 2013.

Vanderbilt Stallworth Rehab Hospital	Discharges	Inpatient Days	% of Total Based on Discharges
Self-Pay	1	5	0.0%
Commercial	563	8,395	38.8%
Medicaid/Tenncare	43	769	3.0%
Medicare	767	10,328	52.8%
Workers Comp	30	391	2.0%
Other	50	860	3.4%
Total	1,454	20,748	100.0%

Source: Tennessee Department of Health. Joint Annual Report of Hospitals, 2013

James H. and Cecile Quillen Rehab Hospital	Discharges	Inpatient Days	% of Total Based on Discharges
Self-Pay	40	450	7.2%
Commercial	73	880	12.8%
Medicaid/Tenncare	10	135	2.0%
Medicare	444	5,885	78.0%
Workers Comp	1	18	0.0%
Other	1	16	0.0%
Total	569	7,384	100.0%

Source: Tennessee Department of Health. Joint Annual Report of Hospitals, 2013

19. **Section C, Economic Feasibility, Item 11(a)**
This project was selected as the best alternative in lieu of remaining in the present location on the hospital campus. In terms of cost effectiveness, what is the approximate/estimated cost to modernize the current 48-bed unit at the hospital with all private beds, increased gym & patient dining space and how does it compare to the $12.7 million cost for new construction of the proposed freestanding facility? Please explain.

Response: In evaluating options for improving the physical facility for the West Tennessee Rehabilitation Center, West Tennessee Healthcare evaluated renovating the existing space and building a replacement facility without entering the joint venture model. At that time, the estimated cost to replace the existing facility or renovate the existing space was approximately 14 million. Renovating existing space was subsequently determined to be undesirable because of the configuration and age of the existing space and the related cost to make the space conducive to modern standards.

20. **Section C, Contribution to Orderly Development, Item 3**
The staffing plan for the proposed facility is noted. It appears there is 1 FTE each for RN, LPN and Nurse Aide staff for a total of 3.0 FTE nursing staff budgeted for 24/7 direct nursing care of patients admitted to the proposed hospital. Based on 14,080 patient days, the direct care staffing calculates to approximately 2.26 direct nursing hours per patient per day in Year 1 of the project (14,080 patient days/6,240 direct nursing hours). This staffing plan appears to be lower than might be expected for an inpatient rehabilitation facility. Please clarify.

Response: For year 1, the estimated number of employees is 124.7, of which 86.1 of these positions are clinically related. A typical HealthSouth freestanding facility provides between 6.0 and 6.5 nursing hours per patient day. Using the low end of this estimate and the projected 14,080 patient care days for year 1, there should be approximately 54.5 FTEs staffed by nursing positions.

21. **Section C, Contribution to Orderly Development, Item 7**
If available, please provide the most recent licensure survey and/or Joint Commission accreditation survey for West Tennessee Rehabilitation Center including cited deficiencies and an approved Plan of Correction. If not available for the rehab unit, please provide the information for Jackson-Madison County General Hospital.

Response: Attached as Exhibit 11 is the most recent licensure survey and approved plan of correction from 2011 and the Joint Commission survey from 2013 for the Jackson-Madison County General Hospital; and CARF Survey Report for the West Tennessee Rehabilitation Center dated 2014.

Does the applicant have plans to seek CARF accreditation for the proposed hospital (Commission Accreditation of Rehabilitation Facilities)? Would this be helpful to the proposed facility as a measure of quality, best practices and of potential importance in seeking contracts with managed care organizations? Please briefly comment.

Response: Currently the plans are to have the West Tennessee Rehabilitation Center accredited by The Joint Commission. After opening the facility, we will evaluate the possibility of seeking CARF accreditation. The accreditation by The Joint Commission will be helpful and useful as a measure of quality, best practices, and seeking contacts with managed care organizations.

Should you have any questions or require additional information about our responses, please contact me at vicki.lake@wth.org or (731) 984-2160.

Sincerely,

Victoria S. Lake
Director, Market Research and Community Development

cc: Walter Smith, HealthSouth Corporation
Dan Elrod, Butler Snow
Currie Higgs, West Tennessee Healthcare
Jeff Blankenship, West Tennessee Healthcare

SUPPLEMENTAL #1
October 29, 2015
10:16 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Madison

NAME OF FACILITY: West Tennessee Rehabilitation Center

I, VICTORIA S. LAKE, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Victoria S. Lake
Signature/Title
Director Market Research
Community Development

Sworn to and subscribed before me, a Notary Public, this the 26 day of October, 2015, witness my hand at office in the County of Madison, State of Tennessee.

Randall L Hampton
NOTARY PUBLIC

My commission expires 9-21, 2016.

HF-0043

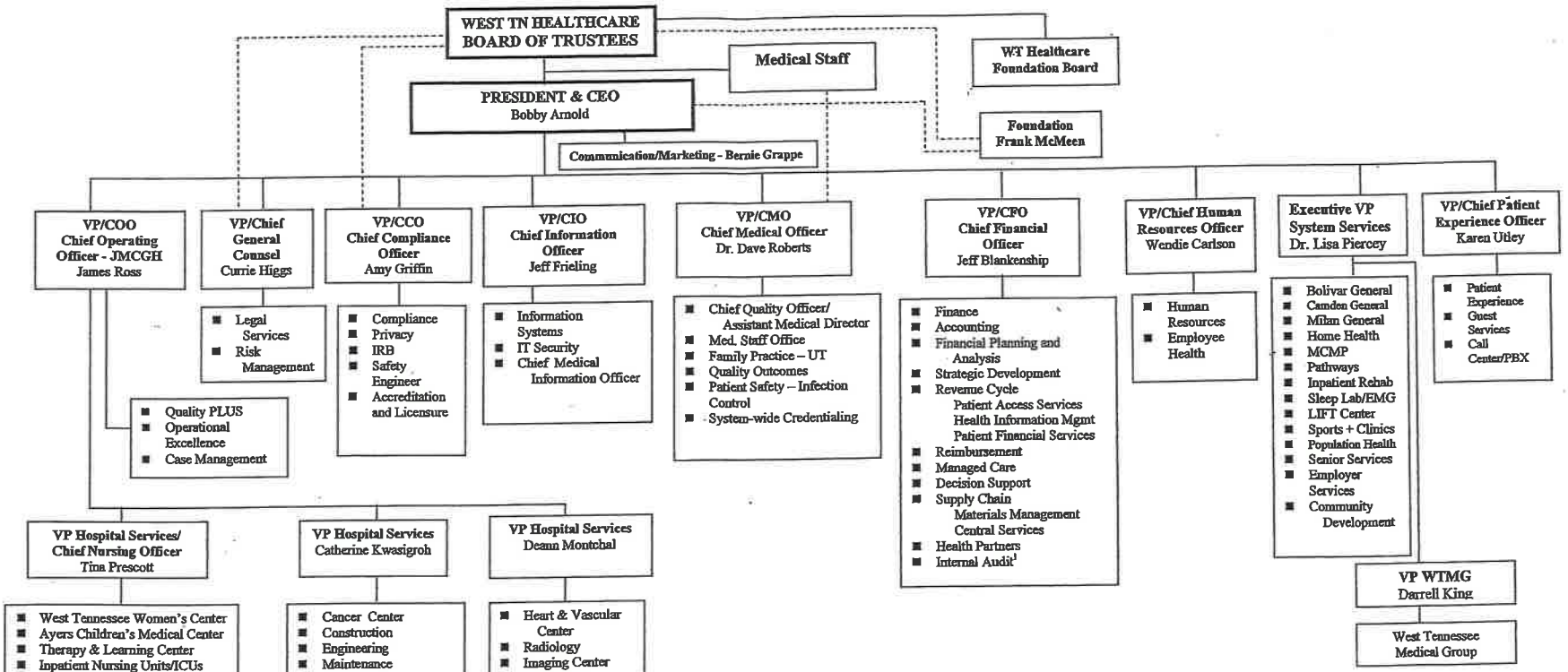
Revised 7/02

RANDALL L HAMPTON
STATE OF TENNESSEE
NOTARY PUBLIC
MADISON COUNTY TN

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Exhibit 1

WEST TENNESSEE HEALTHCARE
Management Organizational Chart
Effective: November 1, 2015



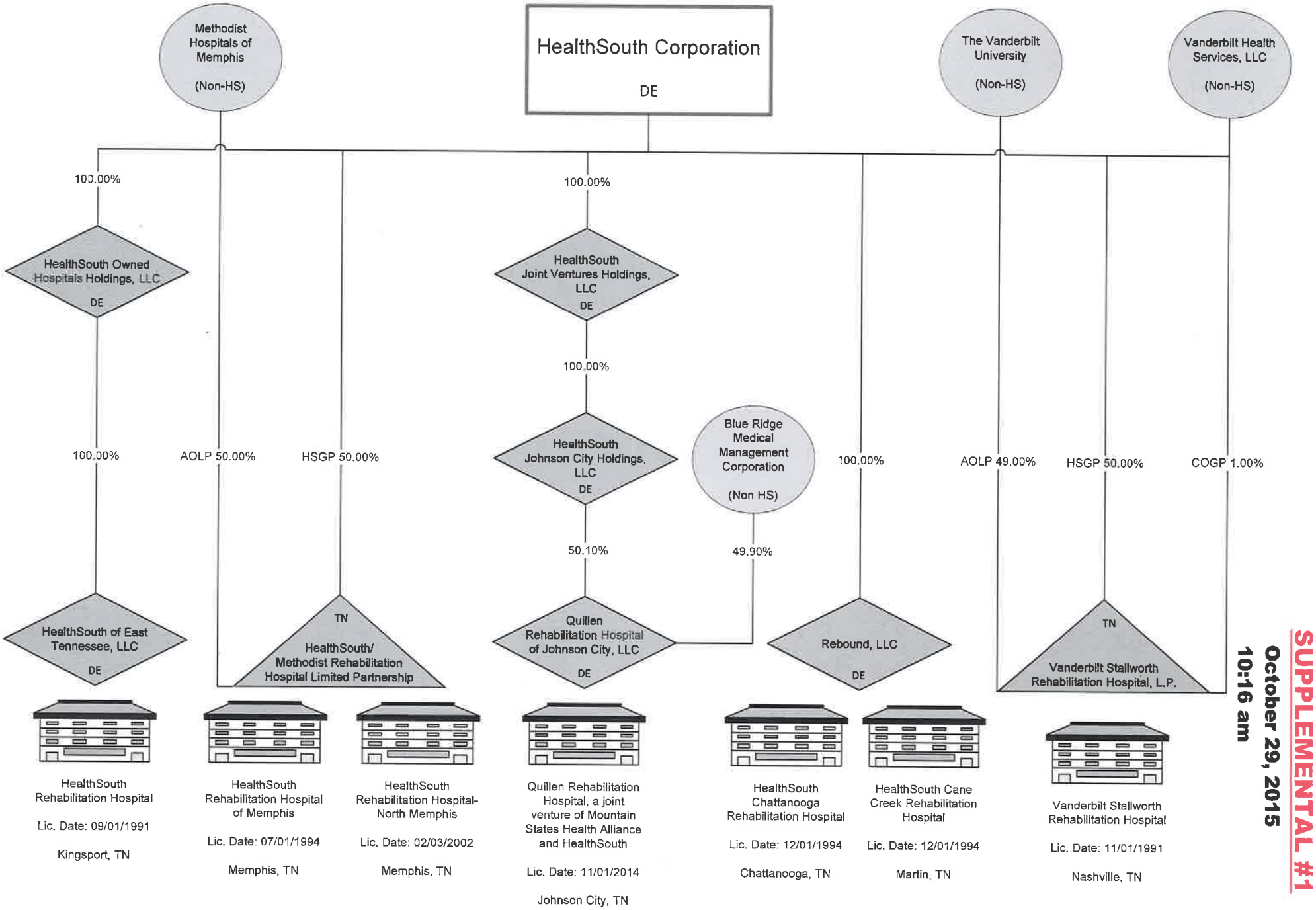
Bobby Arnold

[1]Internal Audit's primary reporting responsibility is to the Board of Trustees. Management oversight of the department is provided by the CFO.

SUPPLEMENTAL #1

October 29, 2015
10:16 am

HealthSouth Tennessee Facilities as on 10/23/2015



SUPPLEMENTAL #1

October 29, 2015
10:16 am

SUPPLEMENTAL #1

October 29, 2015
10:16 am

Exhibit 2

SUPPLEMENTAL #1

October 29, 2015
10:16 am

THIS INSTRUMENT PREPARED BY
RAINEY, KIZER, REVIERE & BELL, P.L.C.
Attorneys at Law (70007-WCB)
105 S. Highland Avenue
Jackson, Tennessee 38301

PROPERTY OWNER
& ADDRESS:

West Tennessee Healthcare, Inc.
616 W. Forest Avenue
Jackson, TN 38305

PERSON OR ENTITY RESPONSIBLE
FOR THE PAYMENT OF REAL
PROPERTY TAXES & ADDRESS:
West Tennessee Healthcare, Inc.
620 Skyline Drive
Jackson, TN 38301

Without Survey or Title Examination

I, OR WE, HEREBY SWEAR OR AFFIRM THAT THE ACTUAL CONSIDERATION FOR THIS TRANSFER OR VALUE OF THE PROPERTY TRANSFERRED, (WHICHEVER IS GREATER) IS $ Exempt

Willie Mack Jr.
AFFIANT

SUBSCRIBED AND SWORN TO BEFORE ME THIS THE 1st DAY OF December, 2008.

Mary Ann Cooper

MARY ANN COOPER
STATE OF TENNESSEE
NOTARY PUBLIC
MADISON COUNTY, TENN.

COMMISSION EXPIRATION: July 6, 2010

Map 66M, Group J, Parcels 39.00, 1.00, 34.00 and 33.00

WARRANTY DEED

KNOW ALL MEN BY THESE PRESENTS: That THE JACKSON CLINIC BUILDING LIMITED PARTNERSHIP, a Tennessee limited partnership, ("Grantor") for and in consideration of the sum of One Hundred ($100.00) Dollars, cash in hand paid, and other good and satisfactory consideration, receipt of all of which is hereby acknowledged, has this day bargained and sold, and does hereby alien, transfer, and convey unto WEST TENNESSEE HEALTHCARE, INC., a Tennessee nonprofit corporation and governmental instrumentality of Jackson-Madison County General Hospital District, ("Grantee") those certain lots and/or parcels of real estate lying and being in the Fifth Ward of the City of Jackson, Madison County, Tennessee, and more particularly bounded and described on the attached EXHIBIT A.

TO HAVE AND TO HOLD the above-described real estate, together with all

Madison County Assessor
Map 66M GP J Par 39 etal CP ___ PR ___

Book D696 Page 1583 Value Ø Date 12-1-08

easements and appurtenances thereunto belonging, unto the said WEST TENNESSEE HEALTHCARE, INC., its transferees, successors and assigns forever.

The Grantor covenants that it is lawfully seized and possessed of the above property; that it has full right to sell and convey the same as aforesaid; that said property is free of all liens and encumbrances with the exception of those matters as set forth on EXHIBIT B to which this conveyance is made subject.

With such exceptions Grantor will forever warrant and defend the title to said property unto the Grantee, its transferees, successors and assigns, against the lawful claims of all persons whomsoever.

IN WITNESS WHEREOF, the Grantor has caused its name to be hereunto subscribed by its authorized officer on this the 1 day of December, 2008.

THE JACKSON CLINIC BUILDING LIMITED PARTNERSHIP

By: JACKSON CLINIC, P.A., its General Partner
By: Kevin P. McMahon
Title: General Counsel

STATE OF TENNESSEE
COUNTY OF

Before me personally appeared Kevin P. McMahon, with whom I am personally acquainted, (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged such person to be General Counsel of the JACKSON CLINIC, P.A., the General Partner of THE JACKSON CLINIC BUILDING LIMITED PARTNERSHIP, the within named grantor, a partnership, and that such person, as such partner, executed the foregoing instrument for the purposes therein contained, by personally signing as the General Counsel of the General Partner of the THE JACKSON CLINIC BUILDING LIMITED PARTNERSHIP.

Witness my hand this 1 day of December, 2008.

DONALD D. GLENN NOTARY PUBLIC STATE OF TENNESSEE NOTARY PUBLIC MADISON COUNTY

My commission expires: 9/18/12

EXHIBIT A

Lying and being in the Fifth Civil District of Madison County, Tennessee, to-wit:

TRACT I:
BEGINNING at a stake in the south margin of Forest Avenue (formerly Omar Road) at a point 254 feet west of the northeast corner of a 12 acre tract of W.A. Hall, of which this tract is a part, and being 30 feet west of the northwest corner of the gin lot which was conveyed from said 12 acre tract by deed of record in Deed Book 117, page 503, runs thence west with the south margin of said Forest Avenue 354 feet to a stake at the northeast corner of Reams' lot; runs thence south 150 feet to a stake; runs thence west 90 feet to center of ditch; runs thence with ditch south 16 degrees 165 feet; thence south 11 degrees west 792 feet; runs thence north 64 degrees east 396 feet; thence north 55 degrees east 175 feet; thence leaving ditch north 4 degrees east 820 feet to the point of beginning containing 8.8 acres. Description taken from prior deed.

INCLUDED IN THE ABOVE DESCRIBED TRACT BUT EXPRESSLY EXCLUDED is the following tract of land conveyed to Wychmere Corporation by deed recorded in Deed Book 219, page 496, in the Register's Office of Madison County, Tennessee, and described as follows:
BEGINNING at a stake in the west margin of Forest Cove, said stake being south 4 degrees 17 minutes west 442.5 feet from the south margin of West Forest Avenue, said point also being at the southeast corner of the 4.0 acre tract of The Jackson Clinic as shown on the plat of the Forest Cove Subdivision, said subdivision plat having been placed of record in the Register's Office of Madison County, Tennessee, immediately preceding the filing of this instrument for recording; runs thence north 89 degrees west with the south line of said Jackson Clinic 4.0 acre tract 407.0 feet to a stake in the center of a sand ditch; runs thence south 15 degrees 13 minutes west with the center of said ditch 158.3 feet to a stake; runs thence south 9 degrees 37 minutes west with the center of said ditch 500.0 feet to a stake in the center of another sand ditch; runs thence north 49 degrees east with the center of said ditch 266.0 feet to a stake; runs thence north 70 degrees east with the center of said ditch 192.2 feet to a stake; runs thence north 40 degrees east with the center of said ditch 160.0 feet to a stake; runs thence north 70 degrees east with the center of said ditch 29.0 feet to a stake; runs thence north 4 degrees 17 minutes east leaving said ditch 160.0 feet to a stake in the south margin of the cul-de-sac of Forest Cove; runs thence in a northwesterly direction with the margin of said Forest Cove following a curve having a radius of 50 feet, a distance of 120.59 feet to a stake; runs thence in a northeasterly direction with the west margin of Forest Cove following a curve having a radius of 25 feet, a distance of 21.03 feet to the point of beginning, containing 4.6 acres, more or less, as surveyed by E. R. Dike & Son, Civil Engineers, on November 18, 1964.

TRACT II:
BEGINNING at a stake in the south margin of Forest Avenue Extended and in a ditch, said stake being at the northwest corner of the Hall tract; runs thence east with the south margin of Forest Avenue 136 feet to a stake; thence south 150 feet to a stake; thence west 70 feet to a ditch; thence with said ditch in a northwesterly direction 165 feet to the point of beginning. Description taken from prior deed.

Being part of the same property conveyed to The Jackson Clinic Building Limited, a limited partnership, by Quitclaim Deed dated March 2, 1981, appearing of record in Deed Book 412, page 203, in the Register's Office of Madison County, Tennessee, and being the same property

conveyed to The Jackson Clinic Building, Limited, a limited partnership, by Quitclaim Deed dated October 16, 1972, appearing of record in Deed Book 279, page 121, in said Register's Office.

TRACT III:
All of that property lying east of the eastern boundary of Lot No. 2 as described in the plat dated October 4, 1983, No. 1448-66-M prepared by McAlexander Engineering entitled "Plat of Property - The Jackson Clinic" attached hereto as Appendix 1 and incorporated herein ("Plat"), including all of grantor's interest as a riparian owner of and with respect to that certain ditch running along or near the east line of said Lot No. 2, being also Lot No. 2 of JOHN. Omar Subdivision, Block II, a plat and revised plat of which property appears of record in Plat Book 1, page 205, and Plat Book 1, page 211, respectively, in the Register's Office of Madison County, Tennessee. Description taken from prior deed.

Being the same property conveyed to The Jackson Clinic Building Limited, a limited partnership, by Quitclaim Deed dated October 27, 1983, appearing of record in Deed Book 437, page 259, in the Register's Office of Madison County, Tennessee.

TRACT IV:
All of that property lying east of the eastern boundary of Lot No. 3 as described in the Plat attached hereto as Appendix 1, including all of grantor's interest as a riparian owner of that certain ditch running along or near the east line of said Lot No. 3 of J. H. Omar Subdivision, specifically Lot 3, Block II, a plat and revised plat of which property appears of record in Plat Book 1, page 205, and Plat Book 1, page 211, in the Register's Office of Madison County, Tennessee. Description taken from prior deed.

Being the same property conveyed to The Jackson Clinic Building Limited, a limited partnership, by Quitclaim Deed dated October 19, 1983, appearing of record in Deed Book 437, page 261, in the Register's Office of Madison County, Tennessee.

Map 66M Group J Parcel 39.00

TRACT V:
Beginning in the northeast corner of a tract of land conveyed to J. H. Omar by R. B. Hicks and wife by deed appearing of record in the Register's Office of Madison County, Tennessee, in Deed Book 65, page 583, of which this lot is a part, said beginning point being also in the south margin of Forest Avenue (formerly Omar Lane), and runs thence west with its north line 91 feet to a stake at the northeast corner of a lot conveyed to L.A. Bugg and wife; thence south with said Bugg's east line 236 feet to a stake at Bugg's southeast corner; thence east 154 feet to a stake in a ditch or gully on the east line of the tract conveyed to Omar by Hicks; thence in a northwesterly direction with the meanderings of said ditch or gully to the point of beginning. Description taken from prior deed.

TRACT VI:
Beginning at a stake at the northwest corner of the tract of land conveyed to Robert L. Paschall and wife by T. D. Barham and wife on January 28, 1943, by deed recorded in the Register's Office of Madison County, Tennessee, and in the south margin of Forest Avenue (formerly Omar Lane), and runs thence east 50 feet to a stake; thence south 236 feet to a stake, a corner with Paschall; thence west 50 feet to a stake, the southwest corner of the original Barham tract; thence north 236 feet to the beginning; this being the western 50 feet of the tract above referred to. Description taken from prior deed.

Being the same property conveyed to Jackson Clinic Building Limited, a limited partnership by deed dated March 21, 1974, appearing of record in Deed Book 299, page 202, in the Register's Office of Madison County, Tennessee.

TRACT VII:
BEGINNING at a stake in the east margin of Linda Vista Drive, at the southwest corner of the Ramsey Lot, said Beginning point being about 236 feet south of West Forest Avenue; runs thence east with the south line of said Ramsey lot 194 feet to the west bank of said ditch; thence in a southeasterly direction with the bank of said ditch to the northeast corner of Lot 2, Block 2, of the John H. Omar Subdivision, a plat of which appears of record in Plat Book 1, page 211, in the Register's Office of Madison County, Tennessee; thence west with the north line of Lot No. 2 in said block 200 feet to its northwest corner of Linda Vista Drive; thence north 80 feet to the point of beginning, and being Lot No. 1 in Block 2 of said Subdivision. Description taken from prior deed.

Being the same property conveyed to Jackson Clinic Building Limited, a limited partnership by deed dated August 15, 1983, appearing of record in Deed Book 435, page 731, in the Register's Office of Madison County, Tennessee.

Map 66M Group J Parcel 1.00

TRACT VIII:
BEGINNING at a stake the south margin of West Forest Avenue at the northwest corner of the Wooten Subdivision; runs thence west with the south margin of West Forest Avenue 224 feet to a stake; thence south 4 degrees west 150 feet to a stake; thence in an easterly direction 199 feet to a stake in the Wooten Subdivision west line; thence in a northerly direction with the west margin of the Wooten Subdivision west line 155 feet, more or less to a stake in the south margin of West Forest Avenue to the point of beginning, and being that tract of land conveyed by Weeks and Hammond to Lett and Hammond by deed of record in Deed Book 149, page 324 in the Register's Office of Madison County, Tennessee. Raymond C. Hammond being deceased and Allene Fain Hammond, now also deceased, having inherited same under the Will of Raymond C. Hammond, and further conveyed to H.J. Lett and wife, Grace C. Lett by deed of the First National Bank of Jackson, Trustee in under the Will of Allene Fain Hammond, Will Book N, page 354, in the Office of the County Court Clerk of Madison County, Tennessee, said deed of record in Deed Book 281, page 439, in the Register's Office of Madison County, Tennessee. Description taken from prior deed.

TRACT IX:
BEGINNING at a stake in the south margin of a public road known as West Forest Avenue, said point being 224 feet west of the northwest corner of the Wooten Subdivision and at the northwest corner of what is commonly called the Hicksville Gin lot, and runs thence west with the south margin of Forest Avenue 5 feet to a stake in the east margin of Forest Cove; thence south 4 degrees west with the east line of Forest Cove 450 feet to a stake at the beginning of a curve to the southeast of the cul-de-sac; thence 130 feet, more or less, around the curve of said cul-de-sac to the centerline extended of Forest Cove; thence south 4 degrees west with the centerline extended 130 feet, more or less, to the north margin of a ditch; thence with the ditch north 62 degrees east 197 feet to a stake at the southwest corner of the Wooten Subdivision; thence north 13 degrees 10 minutes east with the west line of Wooten tract 424 feet to a stake at the southeast corner of the Hicksville Gin lot; thence west 199 feet with the south line of the gin lot to a stake at the southwest corner of said gin lot; thence north 4 degrees east 150 feet with the west line of the gin lot to the

point of beginning, and being a portion of that property conveyed to Mrs. Grace C. Lett by deed of record in Deed Book 176, page 331 in the Register's Office of Madison County, Tennessee.

Since the herein conveyed property was acquired by H.J. Lett and wife, Grace C. Lett and Raymond Hammond, a plat was recorded of the Forest Cove Subdivision in Plat Book 2, page 101, in the Register's Office of Madison County, Tennessee, wherein a roadway designated as Forest Cove was dedicated for public use. A portion of the property acquired by grantor Mrs. Grace C. Lett in Deed Book 176, page 331, Register's Office of Madison County, Tennessee, was used for the said roadway and it is the intention of the grantors to convey to grantee all the property acquired in Deed book 149, page 324, Deed Book 281, page 439 and Deed Book 176, page 331, in the Register's Office of Madison County, Tennessee, and bounded on the north by Forest Avenue, bounded on the west by Forest Cove and Medicenter, bounded on the south by a ditch and bounded on the east by lots 12, 13, 14, 15 and 16 of the Wooten Addition Subdivision recorded in Plat Book 1, page 173, in the Register's Office of Madison County, Tennessee.
Description taken from prior deed.

Being part of the same property conveyed to The Jackson Clinic Building, Limited, a limited partnership, by Quitclaim Deed dated March 2, 1981, appearing of record in Deed Book 412, page 203, in the Register's Office of Madison County, Tennessee, and being the same property conveyed to The Jackson Clinic Building Limited, a limited partnership, by Deed dated January 2, 1973, appearing of record in Deed Book 281, page 441, and corrected by Deed of Correction dated March 20, 1973, appearing of record in Deed Book 287, page 345, in said Register's Office.

TRACT X:
BEGINNING at a stake in the West margin of Lambuth Boulevard at a point five feet south of the Southeast corner of Lot #12 of the Wooten Addition, said point being the Southeast corner of a five foot strip off of Lot #13 in said subdivision, conveyed by Frank W. Young and wife to W. G. Taylor; runs thence West 177.5 feet to a stake; thence in a Southerly direction to a stake in the Northwest corner of Lot #14 in said Wooten Addition; thence East with the North line of Lot #14, 195 feet to the West margin of Lambuth Boulevard, 70 feet to the beginning. Description taken from prior deed.

Being the same property conveyed to The Jackson Clinic Professional Association, by deed dated December 30, 1975, appearing of record in Deed Book 322, page 384, in the Register's Office of Madison County, Tennessee. The Jackson Clinic Professional Association conveyed its interest to Jackson Clinic Building Limited, a limited partnership, by deed dated November 26, 2008, appearing of record in Book D696, page 1500, in the Register's Office of Madison County, Tennessee.

TRACT XI:
BEGINNING at an iron pin at the intersection of the south margin of West Forest Avenue and the west margin of Lambuth Boulevard, and runs thence west with the south margin of Forest Avenue 160 feet to an iron pin; runs thence in a southerly direction (South 12 degrees west) 82 feet, more or less, to an iron pin; thence east 177.5 feet to an iron pin in the west margin of Lambuth Boulevard; thence north with the west margin of Lambuth Boulevard 80 feet to the point of beginning. Being all of Lot No. 12 and the northern five feet of Lot No. 13 of the Wooten Addition to the City of Jackson, Tennessee, a plat of which appears of record in Plat Book 1, page 173, in the Register's Office of Madison County, Tennessee. The above description was taken from a survey made by E. R. Dike, C.E., on February 18, 1949. Description taken from prior deed.

Being the same property conveyed to Jackson Clinic Building Limited by deed dated April 20, 1981 appearing of record in Deed Book 408, page 486, in the Register's Office of Madison County, Tennessee.

Map 66M Group J Parcel 34.00

TRACT XII:
BEGINNING at a stake in the west margin of Lambuth Boulevard, at a point 150 feet south of the south margin of Forest Avenue, the southeast corner of Lot No. 13 of Wooten Addition to the City of Jackson, and runs thence west with the south line of said Lot No. 13, a distance of 195 feet to a stake; thence in a southerly direction 77 feet to a stake, the northwest corner of Lot No. 15 of said Subdivision; thence east with the north line of said Lot No. 15 a distance of 212.5 feet to a stake in the west margin of Lambuth Boulevard; thence north with the west margin of Lambuth Boulevard 75 feet to the point of beginning. Being designated as Lot No. 14 of the Wooten Addition to the City of Jackson, Tennessee, a plat of which appears of record in Plat Book 1, page 173, in the Register's Office of Madison County, Tennessee. Description taken from prior deed.

Being the same property conveyed to Jackson Clinic Building Limited by deed dated October 3, 1988, appearing of record in Deed Book 482, page 774, in the Register's Office of Madison County, Tennessee.

Map 66M Group J Parcel 33.00

The Jackson Clinic Building Limited Partnership, a Tennessee limited partnership, is one and the same as Jackson Clinic Building Limited, a Tennessee limited partnership, or any variation thereof.

EXHIBIT B

1. 2008 property taxes, which are to be prorated between the Grantor and Grantee herein as of the date of this instrument.

2. All matters affecting said lots appearing of record in Plat Book 1, page 173, Plat Book 1, page 211, and Plat Book 2, page 101, in the Register's Office of Madison County, Tennessee.

3. Easements for Electric Distributions Lines to the City of Jackson appearing of record in Deed Book 224, page 179, Deed Book 385, page 252, Deed Book 474, page 826, and Deed Book 534, page 572, all in the Register's Office of Madison County, Tennessee.

4. As to Tracts I, V and VII, Grant of Utility Easement to The City of Jackson appearing of record in Deed Book 441, page 582, in the Register's Office of Madison County, Tennessee.

5. As to Tracts II and V, Grant of Access Easement and Construction Easement to the Jackson-Madison County General Hospital District, for the purpose of operating, repairing and maintaining a pedestrian walkway over West Forest Avenue, dated February 3, 1998, appearing of record in Book D593, page 765, in the Register's Office of Madison County, Tennessee.

6. As to Tract II, Grant of Communications Systems Easement to West Tennessee Healthcare, Inc. dated December 1, 2004, appearing of record in Book D662, page 645, in the Register's Office of Madison County, Tennessee.

7. As to Tract IX, all rights of riparian owners in the ditch located on the south of subject property.

BK/PG:D696/1583-1590
08017661

8 PGS : AL - DEED	
LINDA BATCH: 69974	
12/02/2008 - 12:12 PM	
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	40.00
DP FEE	2.00
REGISTER'S FEE	0.00
TOTAL AMOUNT	42.00

STATE of TENNESSEE, MADISON COUNTY
LINDA WALDON
REGISTER OF DEEDS

SUPPLEMENTAL #1
October 29, 2015
10:16 am

70297102615-WCB

STATE OF TENNESSEE :
COUNTY OF MADISON :

INTENT TO LEASE AGREEMENT

This **INTENT TO LEASE AGREEMENT** (this "**Agreement**") is made and entered into effective as of the ___ day of October, 2015, by and between **WEST TENNESSEE HEALTHCARE, INC.**, a Tennessee nonprofit corporation and governmental instrumentality of Jackson-Madison County General Hospital District ("**Landlord**"), and **WEST TENNESSEE REHABILITATION HOSPITAL, LLC**, a Delaware limited liability company ("**Tenant**").

W I T N E S S E T H:

WHEREAS, Landlord owns that certain tract or parcel of land located at 616 West Forest Avenue in Jackson, Tennessee, which land is more particularly described on Exhibit A attached hereto and incorporated herein by this reference (the "**Land**"), and intends to enter into a Ground Lease ("**Ground Lease**") with Tenant; and

WHEREAS, Tenant is a joint venture between Jackson-Madison County General Hospital District and HealthSouth West Tennessee Holdings, LLC, and the Tenant will provide rehabilitation services to people of the Jackson-Madison County area; and

WHEREAS, Tenant intends to construct certain improvements on the Land (a "**Building**") and necessary parking and other infrastructure improvements ("**Other Improvements**") (the Other Improvements together with the Building, collectively the "**Improvements**"), pursuant to the terms of a Consulting Services Development Agreement; and

WHEREAS, the public will benefit from the enhanced delivery of patient care services in the form of a new rehabilitation facility.

NOW, THEREFORE, In consideration of the rent to be paid, the mutual covenants and agreements herein contained, and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

ARTICLE 1.
PREMISES

Landlord intends to demise and rent the Land unto Tenant, and Tenant intends to rent and hire from Landlord the Land, herein called the Leased Premises, together with any and all improvements located thereon and appurtenances thereto (collectively, the "**Demised Premises**"); together with the non-exclusive right of ingress and egress for pedestrian and vehicular traffic to and from the Building over all sidewalks and walkways and roadways as reflected as Ingress and Egress areas on a recorded plat in the Register's Office of Madison County, Tennessee, on Landlord's property adjacent to the Demised Premises.

The foregoing rights and easements shall be appurtenant to the Demised Premises and are hereinafter included in the definition of the Demised Premises.

ARTICLE 2.
TERM OF LEASE AND RENTAL

Unless the Ground Lease is terminated pursuant to the provisions to be agreed upon, the initial term of the Ground Lease shall be for a period of twenty (20) years (the "**Initial Term**"), commencing on the commencement date set forth in the Ground Lease (the "**Commencement Date**"), and ending on the last day of the month during which the twentieth (20th) anniversary of the Commencement Date occurs (the "**Expiration Date**"). On or about the Commencement Date, Landlord and Tenant shall execute a written agreement establishing the Commencement Date.

Renewal terms will be available as agreed between Landlord and Tenant (a "**Renewal Term**"). The Initial Term, together with all exercised Renewal Terms, shall hereinafter be referred to as the "**Term**".

Rent shall be as established between Landlord and Tenant based on the appraised fair market value rent for the Demised Premises, as may be adjusted during the Term.

ARTICLE 3.
LANDLORD IMPROVEMENTS

Prior to the Commencement Date, Landlord, at its sole cost and expense, intends to raze the building structures on the Land and remove the debris therefrom, and leave the Land in such condition as exists after the debris removal (i.e. not pad ready). Further, Landlord intends to make available, or cause to be made available to the Demised Premises, all utilities and similar services (together "**Utilities**"), including without limitation water, sewer, gas, electricity, telephone and telecommunications. The razing of the existing structures on the Land and providing the availability of utilities shall be referred to as the "**Landlord Improvements**." Such Utilities are planned to be made available to the Demised Premises at or prior to the Commencement Date, or at such other time as such shall be acceptable to Tenant and shall be made available in such quantities or having such capabilities and capacities as are consistent with the intended use of the Demised Premises. No other Landlord Improvements to the Demised Premises are required as a condition of the Ground Lease. All other improvements are the responsibility of Tenant.

ARTICLE 4.
TENANT IMPROVEMENTS AND ALTERATIONS

Tenant intends to develop, construct and operate upon the Demised Premises, at its sole cost and expense, the Building and Other Improvements.

ARTICLE 5.
TITLE AND OWNERSHIP

Landlord is the fee simple owner of the Land. Landlord represents and warrants that Landlord is authorized to execute this Agreement for a Ground Lease for the Term herein granted under the terms and conditions provided herein and that the Ground Lease will be enforceable against Landlord in accordance with its terms. Landlord agrees to provide an opinion of counsel acceptable to Tenant that proper action has been taken by its Board of Trustees to enter into the Ground Lease.

ARTICLE 6.
USE OF PREMISES; QUIET ENJOYMENT

(a) Use Of Premises. The Tenant agrees that the Demised Premises will be used solely and exclusively as a rehabilitation hospital unless otherwise consented to in writing in advance by Landlord, in its reasonable discretion. Further, Tenant agrees that the Demised Premises shall be used and occupied in a lawful manner.

(b) Tenant's Quiet Enjoyment. Landlord covenants that Tenant, on the performance of the terms and conditions of the Ground Lease, will and may peaceably and quietly have, hold and enjoy the Demised Premises for the full term of the Ground Lease, subject to any condemnation provision in the Ground Lease.

ARTICLE 7.
TERMINATION OF LEASE; TITLE TO IMPROVEMENTS

Upon termination of the Ground Lease, either by default of Tenant or expiration of the Term (subject to the terms of the Ground Lease), the Improvements on the Demised Premises will be and become the property of the Landlord.

ARTICLE 8.
SUCCESSORS AND ASSIGNS

The covenants, conditions and agreements contained in the Ground Lease are intended to bind and inure to the benefit of Landlord and Tenant and their respective successors and permitted assigns; provided, however, that, subject to the terms of the Ground Lease, Tenant shall not assign or otherwise transfer its Leasehold Interest without the prior written consent of Landlord, which consent shall not be unreasonably withheld, conditioned nor delayed. Upon a transfer by Landlord or Tenant of its respective estate or interest in the Demised Premises or the Improvements, the transferring party (the "**Transferring Party**") shall notify the other party in writing of such transfer. The Transferring Party will be relieved from any breach of covenants or obligations under the Ground Lease arising or occurring after the date of transfer of the Transferring Party's estate or interest in the Demised Premises or the Improvements.

ARTICLE 9.
DISPUTES

Disputes shall be resolved as agreed between Landlord and Tenant.

ARTICLE 10.
NET LEASE

The Rent payable under the Ground Lease shall be absolutely net to Landlord so as to yield to Landlord in each year during the Term, the Rent so specified, free of any charges, assessments, impositions or deductions of any kind charged, assessed, or imposed on or against the Demised Premises. Except as otherwise specifically provided for by any provision of the Ground Lease, all costs, expenses and obligations of any kind which may arise or become due during the Term relating to the maintenance and operation of the Demised Premises, including all alterations, repairs, reconstruction and replacements as provided in the Ground Lease, shall be paid by Tenant, and Landlord shall be indemnified and saved harmless by Tenant from and against such costs, expenses and obligations.

ARTICLE 11.
GROUND LEASE

Landlord and Tenant acknowledge and agree that a Ground Lease shall be executed upon the granting of a Certificate of Need by the State of Tennessee and completion of information needed to finalize a Ground Lease.

ARTICLE 12.
LEASE CONDITIONED UPON GOVERNMENT APPROVALS

Notwithstanding anything contained in this Agreement or elsewhere to the contrary, Tenant's obligations and Landlord's obligations under the Ground Lease shall be conditioned upon Tenant's attainment of all governmental, quasi-governmental and other approvals (including the issuance of a Certificate of Need by the State of Tennessee) and permits necessary for construction of the Building and its use thereof as a rehabilitation hospital building (collectively, the "**Approvals**") on or before June 30, 2016 (the "**Approvals Deadline**"). Tenant agrees to act diligently, at its expense, in the process of obtaining the Approvals, and Landlord agrees to assist as needed and as requested, in obtaining the Approvals.

Denial of one or more Approvals or the failure of Tenant to obtain all Approvals by the Approvals Deadline shall entitle Tenant or Landlord on each occasion to terminate this Agreement upon written notice to the other party, given within thirty (30) days after a denial or the Approvals Deadline, as applicable. Upon such termination, neither Landlord nor Tenant shall have any further obligations hereunder.

Notwithstanding the foregoing, Tenant shall have the right, in its sole discretion, to extend the Approvals Deadline one (1) or more times, not to exceed a total of one hundred eighty (180)

days, by providing written notice to Landlord of each such extension at least ten (10) days prior to the then-current Approvals Deadline.

[Signature Page Follows]

SUPPLEMENTAL #1
October 29, 2015
10:16 am

IN WITNESS WHEREOF, the parties hereto have executed this Intent to Lease as of the day and year first above written.

LANDLORD:

WEST TENNESSEE HEALTHCARE, INC.,
a Tennessee nonprofit corporation and governmental instrumentality of Jackson-Madison County General Hospital District

By: Billy Andy
Title: CEO

TENANT:

WEST TENNESSEE REHABILITATION HOSPITAL, LLC, a Delaware Limited Liability Company

By: HealthSouth West Tennessee Holdings, LLC
Its: Member

By: Arthur E Wilson Jr
Title: BY: ARTHUR E. WILSON
ITS: AUTHORIZED REPRESENTATIVE

By: Jackson-Madison County General Hospital District
Its: Member

By: Billy Andy
Title: CEO

SUPPLEMENTAL #1
October 29, 2015
10:16 am

EXHIBIT A

[Legal Description of the Land]
PROPERTY DESCRIPTION
5.59 Acres - West Tennessee Healthcare, Inc. Property
City of Jackson, Madison County, Tennessee

A parcel of land located in the City of Jackson, Madison County, Tennessee, being a part of that property conveyed unto West Tennessee Healthcare, Inc. by Warranty Deed of record in Deed Book 696, Page 1583 in the Register's Office of said county, and being more particularly described as follows:

Begin at the intersection of the south right-of-way line of West Forest Avenue (60 foot right-of-way) with the east right-of-way line of Linda Vista Drive (50 foot right-of-way), said point being monumented by a set ½-inch iron rod with aluminum identification cap stamped "PLS INC JACKSON TN" (typical of all iron rods referred to herein as set); thence, with the south right-of-way line of West Forest Avenue, South 87 degrees 00 minutes 59 seconds East, 608.90 feet, to an iron rod set; thence, with the arc of a curve turning to the right, having a radius of 17.50 feet, an arc length of 28.48 feet, and a chord bearing and length of South 40 degrees 23 minutes 11 seconds East, 25.44 feet, to an iron rod set on the west right-of-way line of Forest Cove (50 foot right-of-way); thence, with said west right-of-way line, South 06 degrees 14 minutes 37 seconds West, 423.61 feet, to a ½-inch iron rod found at the northeast corner of Forest Cove Long Term Facility, Inc. (Deed Book 708, Page 815); thence, with the north line of Forest Cove Long Term Facility, North 87 degrees 02 minutes 23 seconds West, passing through an iron rod set on the east side of a drainage ditch at a distance of 362.66 feet, but continuing for an overall distance of 414.12 feet, to a point on the east line of Chelsea and Zachary Livelli (Deed Book 722, Page 1858); thence, with the east line of Livelli, North 07 degrees 06 minutes 13 seconds East, 63.35 feet, to an iron rod set at the southeast corner of Shirley Faye Adams (Deed Book 566, Page 729); thence, with the east line of Adams, North 07 degrees 49 minutes 53 seconds East, 78.53 feet, to a scribe mark set on the top west side of a retaining wall and at the northeast corner of Adams; thence, with the north line of Adams, North 87 degrees 00 minutes 49 seconds West, 200.00 feet, to a magnetic survey nail set in an asphalt drive and on the east right-of-way line of said Linda Vista Drive; thence, with said east right-of-way line, along the arc of a curve turning to the left, having a radius of 131.50 feet, an arc length of 28.60 feet, and a chord bearing and length of North 08 degrees 44 minutes 49 seconds East, 28.54 feet, to a point; thence, continuing with said east right-of-way line, North 02 degrees 30 minutes 59 seconds East, 271.76 feet, to the point of beginning and containing 5.59 acres of land.

Attest:

A. Brent Dean
Tennessee R.L.S. 2205
October 27, 2015

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Exhibit 3

SUPPLEMENTAL #1
October 29, 2015
10:16 am

9. Bed Complement Data Jackson-Madison County General Hospital
Please indicate current and proposed distribution and certification of facility beds.

		Current Beds Licensed	*CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical	226		226		226
B.	Surgical	197		197		197
C.	Long-Term Care Hospital					
D.	Obstetrical	42		42		42
E.	ICU/CCU	75		75		75
F.	Neonatal	34		34		34
G.	Pediatric	13		13		13
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation	48		48	0	0
L.	Nursing Facility - SNF (Medicare only)					
M.	Nursing Facility - NF (Medicaid only)					
N.	Nursing Facility – SNF/NF (dually certified Medicaid/Medicare)					
O.	Nursing Facility – Licensed (non-Certified)					
P.	-IDIHF					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical					
S.	Dependency					
T.	Swing Beds					
U.	Mental Health Residential Treatment					
V.	Residential Hospice					
	TOTAL	**635**		635		**587**

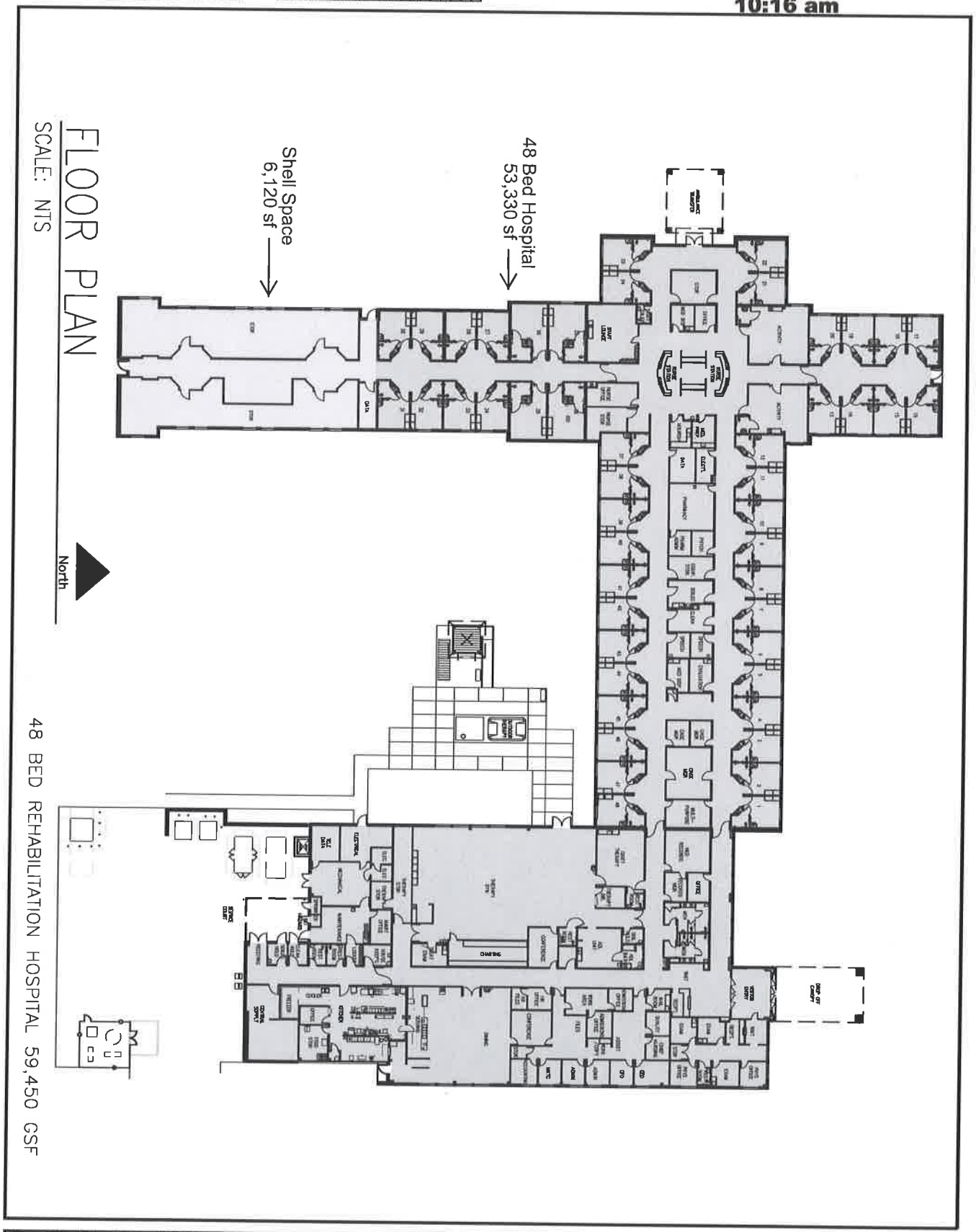
*CON-Beds approved but not yet in service

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Exhibit 4

SUPPLEMENTAL #1

October 29, 2015
10:16 am



48 BED REHABILITATION HOSPITAL
FLOOR PLAN
JACKSON, TN

HEALTHSOUTH.

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Exhibit 5

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response: There will be no change in the number of inpatient rehabilitation beds as a result of this project. Upon approval of this certificate of need and completion of the project, the forty-eight (48) beds currently housed in Jackson-Madison County General Hospital will be delicensed. A letter from the President and CEO of West Tennessee Healthcare, Mr. Bobby Arnold to this effect is attached to this application in **Attachment B.II.B.**

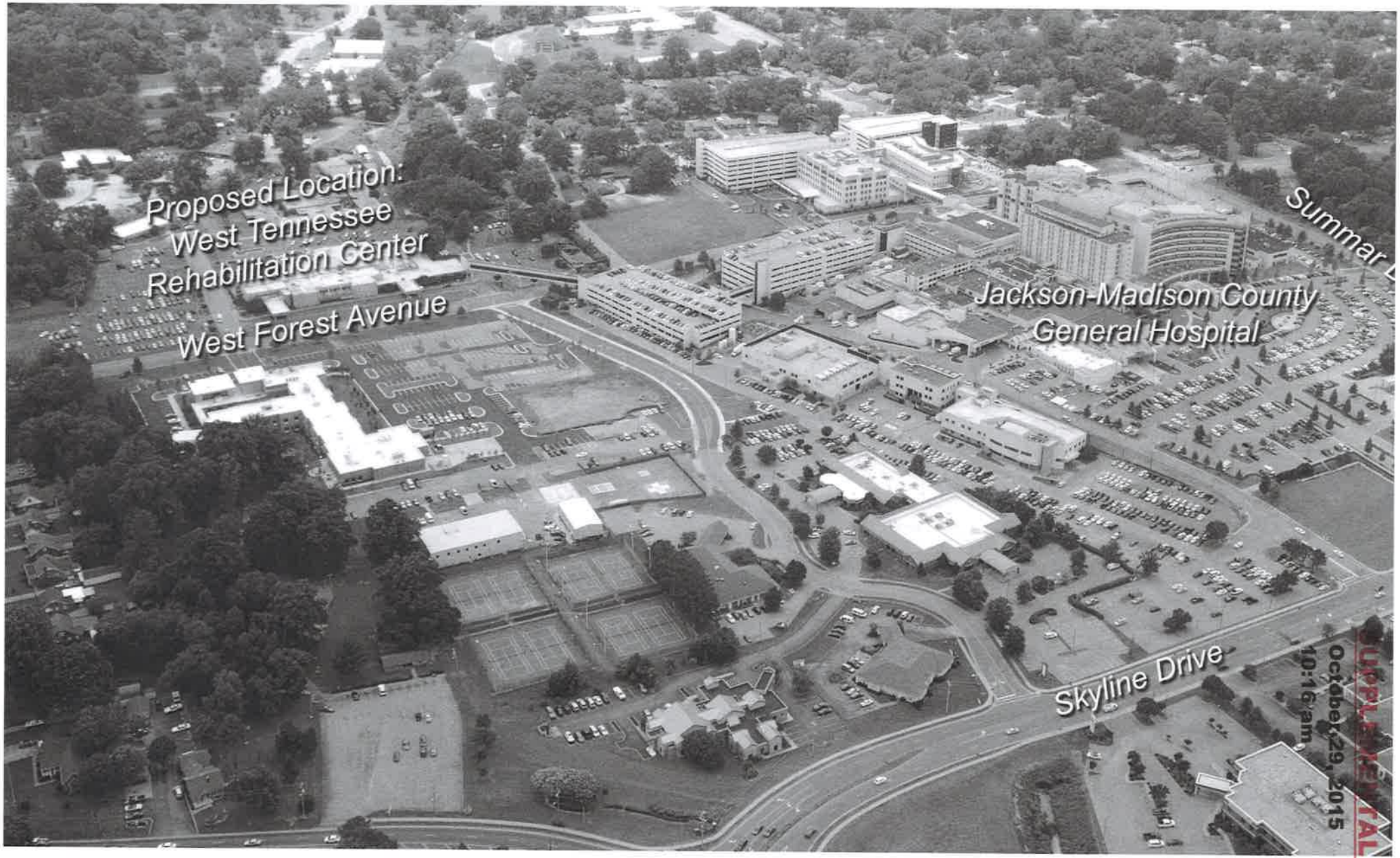
C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. **Adult Psychiatric Services**
2. **Alcohol and Drug Treatment for Adolescents (exceeding 28 days)**
3. **Birthing Center**
4. **Burn Units**
5. **Cardiac Catheterization Services**
6. **Child and Adolescent Psychiatric Services**
7. **Extracorporeal Lithotripsy**
8. **Home Health Services**
9. **Hospice Services**
10. **Residential Hospice**
11. **ICF/MR Services**
12. **Long-term Care Services**
13. **Magnetic Resonance Imaging (MRI)**
14. **Mental Health Residential Treatment**
15. **Neonatal Intensive Care Unit**
16. **Non-Residential Methadone Treatment Centers**
17. **Open Heart Surgery**
18. **Positron Emission Tomography**
19. **Radiation Therapy/Linear Accelerator**
20. **Rehabilitation Services**
21. **Swing Beds**

Response: The project proposed by the applicant, in effect, will replace the existing 48-bed inpatient rehabilitation unit at Jackson-Madison County General Hospital. The project will not add capacity for inpatient rehabilitation services to the market, but it will result in a new, state-of-the-art, dedicated rehabilitation hospital. The need for the project is established by the discussion in response to item D. below.

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Exhibit 6



SUPPLEMENTAL #1

SUPPLEMENTAL #1

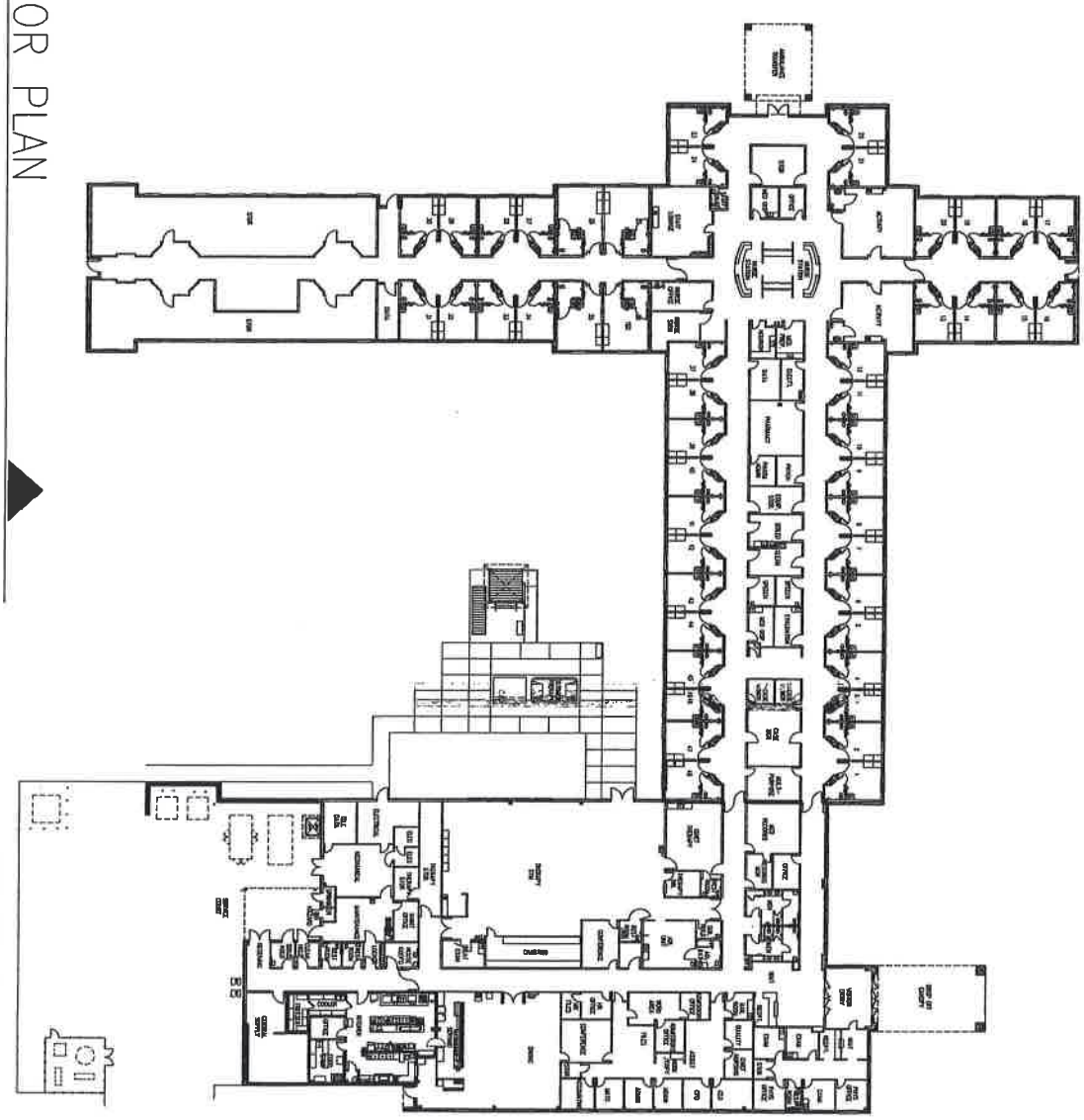
October 29, 2015
10:16 am

Exhibit 7

SUPPLEMENTAL #1
October 29, 2015
10:16 am

FLOOR PLAN

SCALE: 1/16"=1'-0"



48 BED REHABILITATION HOSPITAL 59,450 GSF

FLOOR PLAN	NO. REVISION BY DATE	48 BED REHABILITATION HOSPITAL FLOOR PLAN JACKSON, TN	HEALTHSOUTH

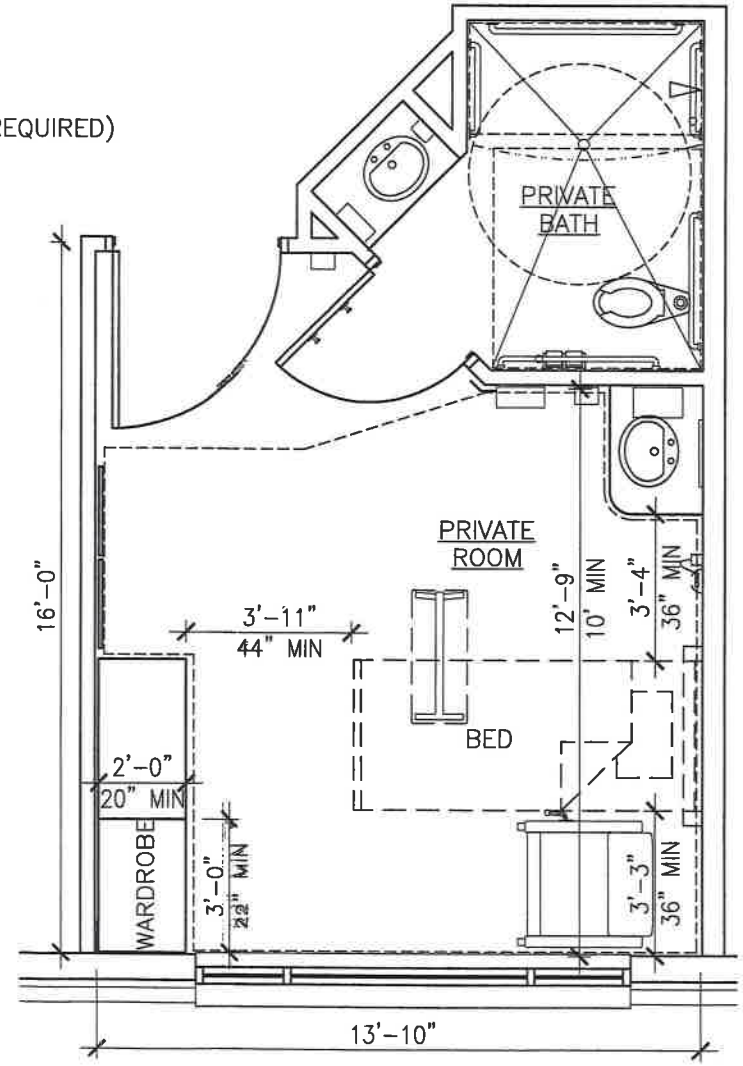
SUPPLEMENTAL #1
October 29, 2015
10:16 am

PATIENT ROOM REQUIREMENTS (FGI 2.6–2.2.2.2)

GROSS ROOM AREA: 199 S.F.
NET ROOM AREA: 148 S.F. (140 S.F. REQUIRED)

GLASS AREA REQUIRED: (FGI 2.1–7.2.2.5)
148 S.F. x .08 = 11.8 S.F.

GLASS AREA PROVIDED: 28.89 S.F.



PRIVATE ROOM PLAN

SCALE: NTS

HEALTHSOUTH.

48 BED REHABILITATION HOSPITAL
FLOOR PLAN
JACKSON, TN

FLOOR PLAN

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Exhibit 8

SUPPLEMENTAL #1
October 29, 2015
10:16 am

CURRICULUM VITAE

DAVIDSON CURWEN, M.D.

MEDICAL TRAINING:
University of California at Los Angeles
Los Angeles, California
Graduated – May 21, 1988
Degree – M.D.

INTERNSHIP:
St. Vincent's Hospital
New York, New York
July 1988 – June 1989
Medicine

RESIDENCY:
St. Vincent's Hospital
New York, New York
July 1989 – June 1992

BOARD CERTIFICATION:
Diplomate of the American Board of
Physical Medicine and Rehabilitation

SPECIAL INTERESTS:
Electro-Diagnostic Medicine
Musculoskeletal Medicine
Brain Injury
Spinal Cord Injury
Spasticity Management
Pain Management

HOSPITAL APPOINTMENTS:
Jackson-Madison County General Hospital
Jackson, TN
Medical Director of West TN Rehab Center
1992 – Present

Regional Hospital of Jackson
1999 – Present

MEMBERSHIPS:
American Academy of
Physical Medicine and Rehabilitation

American Board of Physical Medicine
and Rehabilitation

Southern Society of Physical Medicine
and Rehabilitation

American Institute of Ultra-Sound in Medicine

American Association of Neuromuscular &
Electrodiagnostic Medicine

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Exhibit 9

HISTORICAL DATA CHART-Jackson-Madison County General Hospital

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

	Year2013	Year2014	Year2015
A. Utilization Data (Specify unit of measure)	157,609	155,980	162,628
B. Revenue from Services to Patients			
1. Inpatient Services	$679,740,946	$733,844,082	$818,304,463
2. Outpatient Services	585,630,827	660,432,394	782,359,107
3. Emergency Services	98,729,061	107,493,026	134,323,496
4. Other Operating Revenue (Specify) _____	22,689,344	28,066,684	22,619,679
Gross Operating Revenue	**$1,386,790,178**	**$1,529,836,185**	**$1,757,606,745**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$796,995,093	$911,156,035	$1,105,359,548
2. Provision for Charity Care	29,970,783	27,154,403	24,783,175
3. Provisions for Bad Debt	54,048,636	56,712,561	56,123,862
Total Deductions	**$881,014,511**	**$995,022,999**	**$1,186,266,585**
NET OPERATING REVENUE	**$505,775,667**	**$534,813,186**	**$ 571,340,160**
D. Operating Expenses			
1. Salaries and Wages	$240,805,488	$249,605,915	$266,283,120
2. Physician's Salaries and Wages	561,123	2,991,379	6,050,793
3. Supplies	111,546,538	115,238,250	130,731,826
4. Taxes	739,216	726,726	726,159
5. Depreciation	43,775,055	43,964,000	42,320,339
6. Rent	1,933,951	2,300,531	2,389,991
7. Interest, other than Capital	17,506,401	17,248,129	18,327,899
8. Management Fees:			
a. Fees to Affiliates			
b. Fees to Non-Affiliates	7,316,458	6,955,828	6,215,749
9. Other Expenses – Specify on Page 23	66,801,868	79,628,443	80,198,962
Total Operating Expenses	**$491,067,423**	**$519,046,461**	**$553,709,810**
E. Other Revenue (Expenses) – Net (Specify) _____	$0	$0	$0
NET OPERATING INCOME (LOSS)	**$ 14,708,244**	**$ 15,766,726**	**$ 17,630,350**
F. Capital Expenditures			

1.	Retirement of Principal	$	$	$
2.	Interest			
	Total Capital Expenditures	**$0**	**$0**	**$0**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 14,708,244**	**$ 15,766,726**	**$ 17,630,350**

HISTORAL DATA CHART – OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2013	Year 2014	Year 2015
1. Medical Services	$18,529,065	$20,852,715	$21,900,672
2. Utilities	8,372,220	8,907,127	8,942,205
3. Other Service Fees	6,509,653	7,308,550	8,989,329
4. Cost Allocations	4,190,237	4,798,929	5,511,281
5. Equipment Maint Contracts	5,891,551	6,104,402	6,603,125
6. IT Main Contracts	6,254,040	6,371,756	6,677,131
7. Other	17,055,102	25,284,964	21,575,219
Total Other Expenses	**$66,801,868**	**$79,628,443**	**$80,198,962**

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Exhibit 10

SUPPLEMENTAL #1
October 29, 2015
10:16 am

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year2018	Year2019
A.	Utilization Data (discharge days)	14,080	14,846
B.	Revenue from Services to Patients		
1.	Inpatient Services	$25,410,402	$28,239,259
2.	Outpatient Services	127,052	141,196
3.	Emergency Services		
4.	Other Operating Revenue (Specify) _____		
	Gross Operating Revenue	**$25,537,454**	**$28,380,455**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 7,952,694	$ 8,838,041
2.	Provision for Charity Care	686,843	763,307
3.	Provisions for Bad Debt	197,752	219,767
	Total Deductions	**$ 8,837,289**	**$ 9,821,115**
NET OPERATING REVENUE		**$16,700,165**	**$18,559,340**
D.	Operating Expenses		
1.	Salaries and Wages	$8,809,612	$9,051,638
2.	Physician's Salaries and Wages	148,722	151,697
3.	Supplies	893,142	960,595
4.	Taxes	777,474	897,788
5.	Depreciation	1,494,397	1,814,943
6.	Rent	156,520	159,650
7.	Interest, other than Capital		
8.	Management Fees		
	a. Fees to Affiliates	1,362,667	920,907
	b. Fees to Non-Affiliates		
9.	Other Expenses – Specify on Page 23	2,625,731	2,782,548
	Total Operating Expenses	**$16,268,265**	**$16,739,766**
E.	Other Revenue (Expenses) – Net (Specify) _____	$	$
NET OPERATING INCOME (LOSS)		**$ 431,900**	**$ 1,819,574**
F.	Capital Expenditures		
1.	Retirement of Principal	$	$
2.	Interest		
	Total Capital Expenditures	**$**	**$**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 431,900**	**$ 1,819,574**

SUPPLEMENTAL #1
October 29, 2015
10:16 am

PROJECTED DATA CHART – OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Equipment Rental & Maintenance	$ 398,447	$ 428,539
2. Utilities/Telephone (annual)	345,557	352,468
3. Contract Services	756,433	813,562
4. Other Variable Expenses	490,286	527,315
5. CIS Expense	72,000	73,440
6. Insurance/Bonding	233,331	250,953
7. Other Fixed	329,677	336,271
Total Other Expenses	**$2,625,731**	**$2,782,548**

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Exhibit 11

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Ref: Jackson-Madison Compliance Notice May 2011

May 3, 2011

Mr. Bobby Arnold, CEO
Jackson-Madison County General Hospital
620 Skyline Drive
Jackson, TN 38301

RE: Acute Care Hospital – CMS Certification Number (CCN) 44-0002

Dear Mr. Arnold:

Based on a report by the Tennessee State Survey Agency (SSA) of the April 13, 2011 follow-up survey of Jackson-Madison County General Hospital, we find that your institution is now in compliance with the Medicare Conditions of Participation.

The termination action in our letter dated March 1, 2011 has been removed. In view of your compliance with the Medicare conditions, Jackson-Madison County General Hospital an again be recognized as meeting Medicare requirements by virtue of its accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

We appreciate your efforts and steps taken to correct the Medicare deficiencies cited on February 2, 2011, by the Tennessee State Agency. We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program.

If you have questions, please contact Carol Zafiratos at (404) 562-7428.

Sincerely,

Carol Zafiratos /Sac

Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

Cc: State Agency
JCAHO

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite, 4T20
Atlanta, Georgia 30303-8909

March 21, 2011

James Ross, COO
Jackson-Madison County General Hospital
620 Skyline Drive
Jackson, Tennessee 38301

RE: CCN: 44-0002

Dear Mr. Ross:

We are in receipt of your allegation of compliance/plan of correction dated March 17, 2011, for deficiencies cited on the Medicare survey of February 2, 2011. It has been reviewed and is acceptable. We have asked the State Survey Agency to conduct a follow-up visit before your facilities termination date of May 3, 2011. We appreciate your cooperation in this matter.

If you have any questions please contact Carol Zafiratos at (404) 562-7428.

Sincerely,

Sandra M Pace
Associate Regional Administrator
Division of Survey and Certification

CC: State Agency

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Jackson-Madison County General Hospital™
An affiliate of West Tennessee Healthcare
620 Skyline Drive • Jackson, Tennessee 38301 • 731-541-5000 • www.wth.org

March 17, 2011

Carol Zafiratos
Health Insurance Specialist
NLTCCE Branch
Department of Health and Human Services
Centers for Medicare and Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, GA 30303-8909

Dear Ms. Zafiratos:

Enclosed is the Jackson-Madison County General Hospital (440002) provider's plan of correction action as updated. Thank you for your guidance in this process. The principal contact for this document will be Mr. James Ross, Chief Operating Officer at 731-541-6731 or james.ross@wth.org.

Sincerely,

Ron Hill

Ron Hill, MSHA, BA, RRT
Vice President

xc: Celia Skelley
Public Health Consultant Nurse 2
State of Tennessee
Department of Health
West Tennessee Health Care Facilities

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

SUPPLEMENT
October 29, 2015
10:16 am

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS A validation survey was conducted from 1/31/11 - 2/2/11. An entrance conference was conducted on 1/31/11 in the hospital's Board conference room at 8:12 AM with the Compliance Officer. An exit conference was conducted on 2/2/11 at 4:35 PM in the Board conference room with the COO, Compliance Officer, Environmental Services Director, HIM Director, Director of ED/EMS, GI Director, Director of Clinical Development, Administrator, CNO and Executive Secretary. Time was allotted for questions following the explanation of the survey concerns. The following Conditions of Participation were cited as a result of the survey; 482.21 Quality Assessment and Performance Improvement Plan, 482.41 Physical Environment and 482.42 Infection Control The following abbreviations were used in the statement of deficiencies: ABGs - Arterial Blood Gas AJIC - American Journal of Infection Control AM - before noon APIC - Association for Professionals in Infection Control Attn - attention Bipap - sleep apneas machine c - with Chest PT - chest physiotherapy CDC - Centers for Disease Control and Prevention CNO - Chief Nursing Officer COO - Chief Operating Officer CRNA - certified registered nursing anesthetist CNM - certified nurse midwife CT Computed tomography	A 000		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Vice President - Chief Operating Officer 10/29/15

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these ocuments are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	Continued From page 1	A 000		

DC - discharge or discontinue
DDS - dietary director supervisor
EC - executive chef
ED - emergency department
EMS - emergency medical services
eval - evaluation
Flexx - Type of blood glucose meter
g - grams
GI - gastrointestinal
gtt-drop/ drip
HBV - hepatitis B virus
HCV - hepatitis C virus
hep - heparin
HIM - Health Information Manager
HIV - human immunodeficiency virus
hrs - hours
IC - Infection Control
ICU - Intensive Care Unit
IV - intravenously
IVPB - intravenous piggyback
K+ - Potassium
KCL - Potassium chloride
AL - left
LFT- Liver Function Test
LLE - left lower extremity
LUE - left upper extremity
meq - milliequivalent
mg - milligrams
MRSA - Methicillin Resistant Staphylococcus aurous
NS- Normal Saline
O2- oxygen
OFI - opportunities for improvement
PCXR - Portable Chest X-ray
PEG - Percutaneous Endoscopic Gastrostomy
Pharm D - Doctor of Pharmacy
po - by mouth
PM - afternoon / Program Manager
PPE - personnel protective equipment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

October 29, 2015
10:16 am

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	Continued From page 2 PRN - as needed for Pt - Patient P&T - pharmacy & therapeutic protocols------ PT - physical therapy RLE- right lower extremity RUE-right upper extremity RT - respiratory therapist RN - registered nurse Q - every QAPI - Quality Assessment and Performance Improvement RE - regarding RLE - right lower extremity RN - Registered Nurse RT - Respiratory Therapist RUE - right upper extremity s - without s/p - status post SBP- Systolic Blood Pressure Sys - Systolic SICU - surgical intensive care unit STAT - urgent tx - treatment t.o. - telephone order tid- three times daily Tech - technician Vanc- Vancomycin v.o. - verbal order @ - at < - less than > - greater than x - times ^ - increase WOCN - Wound Ostomy Certified Nurse	A 000		
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	October 29, 2015 10:16 am 02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 168	Continued From page 3 licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on medical record review and facility policy review, it was determined the facility failed to ensure a physician's order for restraints was obtained when restraints were utilized for 2 of 5 (Patients #6 and 26) sampled patients with restraints. The findings included: 1. Review of the facility's "Restraints--Clinical Restraint-Medical Interference Protocol" policy revealed the following : "...The use of restraint must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint by hospital policy. If restraints have been initiated by nursing staff, a physician order must be obtained as soon as possible..." 2. Closed medical record review for Patient #6 revealed verbal physician's orders dated 10/15/10 at 8:50 AM, included "Restraints per medical protocol" and ventilator settings. An "Order for Clinical Restraint/Medical Interference Protocol" dated 10/15/10 at 11:15 AM documented, "Protocol criteria for application of restraints: Patient is intubated and may extubate if sedation level decreases or level of cognizance changes." The type of restraint was documented as soft, and location of restraint was documented as LUE and RUE. Documentation	A 168	A168 1. The facility has reviewed the policy "Restraints – Clinical Restraint – Medical Interference Protocol" with all floor and unit department directors on 3/2/11. Mandatory Education by the CNO and each Floor/Unit Director was begun with all nursing staff on 3/4/11 to ensure that restraints initiated by nursing staff have a signed physician order per policy. This education was completed on 3/9/11. Mandatory education by the CNO and each Floor/Unit Director was begun with all nursing staff on 3/4/11 to ensure that assessments of restraints are done every two (2) hours per policy. All new nursing employees will receive appropriate restraint application and monitoring education during new nurse orientation. Restraint competencies will be re-assessed during the mandatory annual skills fair. A daily review of 100% of restrained patients by the Floor/Unit Director was begun on 3/7/11, to continue through 4/1/11, with monthly review thereafter to monitor and ensure this deficiency does not occur in the future. The monthly report will go to the CNO, and then will be reported quarterly to the Medical Care Review, a joint hospital leadership, Board of Directors and Medical Staff Leadership committee.	3/9/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

October 29, 2015
10:16 am

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 168	Continued From page 4 for "Alternatives tried: Change in environment, assess level of consciousness and presence of pain evaluated and relief measures instituted." This form documented the patient's family was notified of the application of restraints and the patient/family educated. Telephone physician's orders, dated 10/19/10 at 10:12 PM included, "Haldol 2 mg IV Q 4 PRN agitation. OK to leave on soft restraints." An "Order for Clinical Restraint/Medical Interference Protocol" dated 10/24/10 at 4:00 PM documented, "Protocol criteria for application of restraints: Patient is confused and is high risk for falling, wandering or interference with medical treatment." Type of restraint applied was marked as soft; location of restraint was marked as LUE and RUE. Alternatives tried were documented as "Invasive site covered, Change in environment, Asses Level of Consciousness, Presence of pain evaluated and relief measures instituted, and Utilize bed alarm monitors." There was no physician's signature on this order. A Physical Therapy Evaluation dated 10/22/10 at 11:44 AM documented, "Pt with vest restraint on 2nd to fall in past several days... Comment: x 2. secured vest restraint B to bed... pt having previous fall per RN and now in vest restraint so pt not left up in bedside chair..." Nurse's Notes dated 10/22/10 at 8:00 AM documented, "Torso Restraint Activity: initiated vest restraint." Nurse's notes documented torso vest restraint was released and reapplied every 2 hours 10/22/10 at 8:00 AM through 10/24/10 at 2:00 AM. Nurse's notes dated 10/24/10 at 2:00 AM	A 168	A168 2. 2. This deficiency will be corrected by the CNO and Floor/Unit Directors educating all nursing staff that 1) all restraint orders must have a signed physician order in the medical record, and 2) additional orders for restraints must be obtained and signed by the physician if the location of the restraint is changed. This education was begun on 3/4/11 and was completed on 3/9/11. Mandatory education by the CNO and each Floor/Unit Director was begun with all nursing staff on 3/4/11 to ensure that assessments of restraints are done every two (2) hours per policy. All new nursing employees will receive appropriate restraint application and monitoring education during new nurse orientation. Restraint competencies will be re-assessed during the mandatory annual skills fair. A daily review of 100% of restrained patients by the Floor/Unit Director was begun on 3/7/11, to continue through 4/1/11, with monthly review thereafter to monitor and ensure this deficiency does not occur in the future. The monthly report will go to the CNO, and then will be reported quarterly to the Medical Care Review, a joint hospital leadership, Board of Directors and Medical Staff Leadership committee.	3/9/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 168	Continued From page 5 documented, "Behavior Requiring Medical Restraint Pt confused/high risk interfering with medical tx, Pt has arterial/venous lines and may pull out, Behavior interfering with medical care, devices, tubes/drain." There was no further documentation of restraints until 10/24/10 at 4:00 PM; nurse's notes at that time documented soft restraints LUE and RUE, and "No evidence of injury related to restraint, Restraints properly applied." The Behavior Requiring Medical Restraint was documented as "Pt confused/high risk for falling/wandering, Pt confused/high risk interfering with medical tx." 3. Medical record review for Patient #26 revealed a verbal order dated 1/18/11 at 5:20 AM that documented "4 Point soft restraints PRN [when needed], Per Protocol." An "ORDER FOR CLINICAL RESTRAINT/ MEDICAL INTERFERENCE PROTOCOL" dated 1/18/11 at 7:00 AM documented, "...Type of restraint applied: ... Soft... Location of restraint: was marked LUE, RUE, LLE, and RLE..." There was no physician's signature on the verbal order written by the nurse. Review of the Nurses Notes dated 1/18/11 from 12:00 PM until 1/19/11 at 2:00 AM documented "Torso Restraint Type Vest." There was no physician order for Vest restraint.	A 168	3. 3. This deficiency will be corrected by the CNO and Floor/Unit Directors educating all nursing staff that 1) it is never acceptable for a restraint order to be written "PRN"; 2) all restraint orders must have a signed physician order in the medical record, and 3) additional orders for restraints must be obtained and signed by the physician if the location of the restraint is changed. This education was begun on 3/4/11 and was completed on 3/9/11. Mandatory education by the CNO and each Floor/Unit Director was begun with all nursing staff on 3/4/11 to ensure that assessments of restraints are done every two (2) hours per policy. All new nursing employees will receive appropriate restraint application and monitoring education during new nurse orientation. Restraint competencies will be re-assessed during the mandatory annual skills fair. A daily review of 100% of restrained patients by the Floor/Unit Director was begun on 3/7/11, to continue through 4/1/11, with monthly review thereafter to monitor and ensure this deficiency does not occur in the future. The monthly report will go to the CNO,and then will be reported quarterly to the Medical Care Review, a joint hospital leadership, Board of Directors and Medical Staff Leadership committee.	3/9/11
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).	A 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 169	Continued From page 6 This STANDARD is not met as evidenced by: Based on policy review and medical record review, it was determined the facility failed to ensure no PRN orders were written for restraint use for 1 of 5 (Patient #26) sampled patients with restraints in accordance with this regulation. The findings included: 1. Review of the facility's "Restraints--Clinical Restraint-Medical Interference Protocol" policy revealed the following : "...The use of restraint must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint by hospital policy. If restraints have been initiated by nursing staff, a physician order must be obtained as soon as possible..." 2. Medical record review for Patient #26 revealed a verbal order dated 1/18/11 at 5:20 AM that documented "4 Point soft restraints PRN, Per Protocol."	A 169	A169 1. The facility has reviewed the policy "Restraints – Clinical Restraint – Medical Interference Protocol" with all floor and unit department directors on 3/2/11. Mandatory education by the CNO and each Floor/Unit Director was begun with all nursing staff on 3/4/11 to ensure that restraints initiated by nursing staff have a signed physician order per policy. This education was completed on 3/9/11. Mandatory education by the CNO and each Floor/Unit Director was begun with all nursing staff on 3/4/11 to ensure that assessments of restraints are done every two (2) hours per policy. All new nursing employees will receive appropriate restraint application and monitoring education during new nurse orientation. Restraint competencies will be re-assessed during the mandatory annual skills fair. A daily review of 100% of restrained patients by the Floor/Unit Director was begun on 3/7/11, to continue through 4/1/11, with monthly review thereafter to monitor and ensure this deficiency does not occur in the future. The monthly report will go to the CNO, and will then be reported quarterly to the Medical Care Review, a joint hospital leadership, Board of Directors and Medical Staff Leadership committee. 2. This deficiency will be corrected by the CNO and Floor/Unit Directors educating all nursing staff that 1) it is never acceptable for a restraint order to be written "PRN". This education was begun on 3/4/11 and was completed on 3/9/11. Mandatory education by the CNO and each Floor/Unit Director was begun with all nursing staff on 3/4/11 to ensure that assessments of restraints are done every two (2) hours per policy. All new nursing employees will receive appropriate restraint application and monitoring education during new nurse orientation. Restraint competencies will be re-assessed during the mandatory annual skills fair. A daily review of 100% of restrained patients by the Floor/Unit Director was begun on 3/7/11, to continue through 4/1/11, with monthly review thereafter to monitor and ensure this deficiency does not occur in the future. The monthly report will go to the CNO, and then will be reported quarterly to the Medical Care Review, a joint hospital leadership, Board of Directors and Medical Staff Leadership committee.	3/9/11 3/9/11
A 175	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by: Based on facility policy review, medical record review, observation and interview, it was determined the facility failed to ensure the nursing staff provided ongoing assessment and	A 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 175	Continued From page 7 monitoring of Clinical Restraints in accordance with the facility's policy for for 1 of 5 (Patient #8) sampled patients with restraints. The findings included: 1. Review of the facility's "Restraints--Clinical Restraint-Medical Interference Protocol" revealed the following: "Patient will be reassessed at least every two (2) hours to determine if they still meet protocol criteria." and "...reassessments by a qualified RN will include, at a minimum, the following: 1. The actual behavior observed. 2. The reason (cause) for the behavior as assessed by the RN. 3. Determination that the patient's behavior is potentially injurious to themselves or others. 4. Alternative methods employed to avoid restraints and the effectiveness of those methods. 5. Criteria used for determining the need for restraint. 6. Discussion with the patient and/or family concerning the use of restraints. I. Documentation of the nursing observations and care provided while the patient is restrained are made by or under the direction of a qualified RN and will include, at a minimum, the following: 1. Fluids are offered every two (2) hours. 2. Mental status of the patient addressed every two (2) hours. 3. Toileting needs addressed every two (2) hours. 4. Circulation of restrained limb observed every two (2) hours. 5. Nutritional needs addressed every two (2) hours. 6. Personal hygiene is addressed at least every eight (8) hours. 7. Vital signs are obtained at least once per shift ..." 2. Medical record review for Patient #8 documented the patient was placed in bilateral wrist restraints on 1/28/11 at 1900. Review of the "Hemodialysis Flowsheet " form	A 175	A175 1. The facility has reviewed the policy "Restraints – Clinical Restraint- Medical Interference Protocol" with all floor and unit department directors on 3/2/11. Mandatory education by the CNO and each Floor/Unit Director was begun with all nursing staff on 3/4/11 to ensure that assessments of restraints are done every two (2) hours per policy. This education was completed on 3/9/11. All new nursing employees will receive appropriate restraint application and monitoring education during new nurse orientation. Restraint competencies will be re-assessed during the mandatory annual skills fair. A daily review of 100% of restrained patients by the Floor/Unit Director was begun on 3/7/11, to continue through 4/1/11, with monthly review thereafter to monitor and ensure this deficiency does not occur in the future. The monthly report will go to the CNO, and then will be reported quarterly to the Medical Care Review, a joint hospital leadership, Board of Directors and Medical Staff Leadership committee. 2. This deficiency will be corrected by the CNO and Floor/Unit Directors educating all nursing staff that 1) all restraint orders must have a signed physician order in the medical record, and 2) restraint assessments are done every two (2) hours regardless of the location of the patient in the facility (inpatient unit versus a procedural area such as Hemodialysis). It will be the responsibility of the procedural area to document restraint assessments every two (2) hours when restrained patients are in their areas. This education was begun on 3/4/11 and was completed on 3/9/11. All new nursing employees will receive appropriate restraint application and monitoring education during new nurse orientation. Restraint competencies will be re-assessed during the mandatory annual skills fair. A daily review of 100% of restrained patients by the Floor/Unit Director was begun on 3/7/11, to continue through 4/1/11, with monthly review thereafter to monitor and ensure this deficiency does not occur in the future. The monthly report will go to the CNO, and then will be reported quarterly to the Medical Care Review, a joint hospital leadership, Board of Directors and Medical Staff Leadership committee.	3/9/11 3/9/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 175	Continued From page 8 dated 1/31/11 revealed no documentation of the patient's behavior, alternative methods attempted, criteria used to determine the need for restraints, discussion with the patient or family concerning the use of the restraint, level of consciousness, mental status, circulation checks, or nutritional needs of the patient. There was no documentation of current restraint orders. Observations on 1/31/11 at 9:35 AM revealed bilateral wrist restraints intact on Patient #8. During an interview in the dialysis unit on 1/31/11 at 0945, when asked if (nurse) would be doing anything (releasing the restraints per facility policy, doing circulation checks or checking for orders) with the restraints, while patient received dialysis from 0915 until the treatment was stopped at 1300, Nurse #2 stated "No." During an interview in the conference room on 2/1/11 at 11:15 AM the Medical Record Supervisor confirmed dialysis patients, in restraints, would need an assessment performed during the treatment.	A 175		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related	A 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 263	Continued From page 9 to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on review of the hospital's policies, ED Committee Minutes and interview, it was determined the hospital failed to ensure the QAPI committee developed, implemented and maintained an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program in order to maximize quality health outcomes. The findings included: 1. The hospital failed to ensure all pts who presented to the ED with post-surgical site MRSA infections were tracked and trended to identify the root cause. Refer to A 267 2. The hospital failed to ensure the QAPI program utilized collected data to monitor the effectiveness and safety of services and quality of care. Refer to A 268 3. The hospital failed to ensure the QAPI program identified opportunities for improvement and implemented changes that would lead to improvement. Refer to A 276	A 263	A263 1. This deficiency will be corrected by incorporating Infection Control Data into the quarterly Department of Emergency Medicine; this will become a routine element of the Executive Directors Quality Report. The Infection Control officer will provide the Executive Director of Emergency Services with a monthly MRSA ED tracking sheet. Infection Control will track and trend MRSA post surgical site infections that arrive in the ED to identify the root cause. This data will be reported to the Infection Control Committee, composed of Infection Control Staff, Infectious Disease physicians, other specialty physicians and hospital leadership, which meets every other month. Any trends identified are reported to the Medical Executive Committee which meets monthly. This deficiency was corrected at the quarterly Department of Emergency Medicine Committee held on March 1, 2011 and at the Infection Control Committee on March 14, 2011. Ongoing compliance will be monitored by review of the meeting minutes of this committee by Quality Outcomes Staff. 2. This deficiency will be corrected by the Executive Director of Emergency Services submitting a Quarterly QA report, which includes the MRSA tracking report, to the Department of Emergency Medicine Committee based on the data collected monthly in the Emergency Department. . This data will be reported to the Infection Control Committee, composed of Infection Control Staff, Infectious Disease physicians, other specialty physicians and hospital leadership, which meets every other month. Any trends identified are reported to the Medical Executive Committee which meets monthly. This deficiency was corrected at the quarterly Department of Emergency Medicine Committee held on March 1, 2011 and at the Infection Control Committee on March 14, 2011. Ongoing compliance will be monitored by review of the meeting minutes of this committee by Quality Outcomes Staff. 3. This deficiency will be corrected by the Executive Director of Emergency Services submitting a Quarterly QA report to the Department of Emergency Medicine Committee based on the data collected monthly in the Emergency Department, as well as the MRSA tracking report provided by Infection control. Trends identified are submitted to Quality Outcomes so that any necessary changes and improvements can be implemented and tracked by the Quality Outcomes Department. Identified trends will be reported to the Infection Control Committee, composed of Infection Control Staff, Infectious Disease physicians, other specialty physicians and hospital leadership, which meets every other month. They are then reported to the Medical Executive Committee which meets monthly. This deficiency was corrected at the quarterly Department of Emergency Medicine Committee held on March 1, 2011 and at the Infection Control Committee on March 14, 2011. Ongoing compliance will be monitored by review of the meeting minutes of this committee by Quality Outcomes Staff.	3/1/11 3/1/11 3/1/11
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient	A 267		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

October 29, 2015
10:16 am

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 267	Continued From page 10 events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on hospital policy, ED Committee Minutes, and interview, it was determined the facility failed to provide QAPI documents that measured, analyzed, and tracked quality indicators. The findings included: 1. The hospital's policy, "Quality+ Plan for Improving Organizational Performance," documented as an objective on page 2, "...to use appropriate statistical tools and techniques to organize and analyze data to identify trends, variations, patterns, and performance levels that suggests opportunities for improvement (OFI)..." 2. ED Committee Minutes for 9/7/10 on page 2 documented a medical director's concern regarding "...a few cases of patients who have come back with surgical site infections," and sent home with antibiotics which, "may or may not work due to the MRSA situation." 3. During an interview in the conference room on 2/2/11 at 3:25 PM the Infection Control (IC) Nurse stated she had knowledge of 5 MRSA cases related to post-op infections presenting to the ED. The IC Nurse would not directly answer any of the questions posed by the surveyors regarding MRSA readmissions to the hospital or if these surgeries were in-house or performed at another facility. The IC Nurse was unable to provide QAPI documents that measured, analyzed, and tracked quality indicators related to MRSA infections in the facility.	A 267	A267 1. The hospital's policy "Quality + Plan for Improving Organizational Performance" has been reviewed and statistical tools and techniques to organize and analyze data to identify trends, variations, patterns, and performance levels that suggests opportunities for improvement (OFI) will be used to enhance the QAPI Program. 2. The MRSA "situation referred to was a reference to the prevalence of MRSA colonization in the community. He was not referring to a MRSA "situation" in the hospital. JMCGH has a robust screening and isolation policy for MRSA. In order to follow up on appropriate antibiotic usage, an electronic power form "Culture Physician Follow Up" was created in January 2011. Positive cultures collected in the Emergency Department are called to the charge nurse, when final results including susceptibility are received the Emergency Room Physician is notified and, the chart is reviewed for appropriate antibiotics and treatment. Staff will document the MD who review the results as well as any additional comments. Positive cultures and antibiotic appropriateness are submitted at the quarterly Department of Emergency Medicine Committee. Ongoing compliance will be monitored by review of all positive cultures being received by the Head Clinical Record Specialist for follow up documentation with Emergency Department physician and the patient when applicable. This process was changed to the above mentioned in January of 2011. The Emergency Department meeting was held on March 1, 2011 and the meeting minutes reflect this report. 3. This deficiency will be corrected by Infection Control providing a monthly tracking and trending report to the Executive Director of emergency services. This report lists any positive MRSA cultures collected in the Emergency Department, as well as source of the organism and, antibiotic appropriateness. Surgical site infections are also tracked for in-house versus surgeries performed at other facilities. Infection Control tracks and trends (cont'd)	2/8/11 3/1/11 3/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 267	Continued From page 11 During an interview in the conference room on 2/2/11 at 3:30 PM, the IC Nurse was asked about the "MRSA situation" in the ED. The Infection Control Nurse stated she did not recognize this as a "situation." Refer to A 750	A 267	A267, 3 cont'd all MRSA positive screens and cultures facility wide for source, appropriate PPE usage, and isolation. This deficiency was corrected at the quarterly Department of Emergency Medicine Committee held on March 1, 2011. Ongoing compliance will be monitored by the ED MRSA tracking report being presented to the Infection Control Committee which meets every other month. Any trends identified will be reported to the Medical Executive Committee which meets monthly. Emergency Department specific data was presented at the March 2011 Department of Emergency Medicine Committee and at the Infection Control Committee on March 14, 2011. Ongoing compliance will be monitored by review of the meeting minutes of this committee by Quality Outcomes Staff	
A 275	482.21(b)(2)(i) QAPI QUALITY OF CARE The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of service and quality of care. This STANDARD is not met as evidenced by: Based on review of hospital policy, ED Committee Minutes review and interview, the facility failed to provide QAPI documents that used collected data to monitor the effectiveness and safety of services and quality of care. The findings include: 1. Facility policy "Quality+ Plan for Improving Organizational Performance," documented as objectives on page 2, "...fostering an organizational-wide commitment to Quality +, Performance Improvement and improving patient safety...establishing quality improvement priorities and principles." 2. ED Committee Minutes for 9/7/10 on page 2 documented a medical director's concern for "...a few cases of patients who have come back with surgical site infections," and sent home with antibiotics which, "may or may not work due to the MRSA situation." 3. During an interview in the conference room on	A 275	A275 1. The hospital's policy "Quality + Plan for Improving Organizational Performance" has been reviewed and data collected will be used to monitor the effectiveness and safety of service and quality of care. 2. The MRSA "situation" referred to was a reference to the prevalence of MRSA colonization in the community. He was not referring to a MRSA "situation" in the hospital. JMCGH has a robust screening and isolation policy for MRSA. In order to follow up on appropriate antibiotic usage, an electronic power form "Culture Physician Follow Up" was created in January 2011. Positive cultures collected in the Emergency Department are called to the charge nurse, when final results including susceptibility are received the Emergency Room Physician is notified and, the chart is reviewed for appropriate antibiotics and treatment. Staff will document the MD who reviews the results as well as any additional comments. Ongoing compliance will be monitored by review of all positive cultures being received by the Head Clinical Record Specialist for follow up documentation with Emergency Department physician and the patient when applicable. (cont'd)	2/8/11 3/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 275	Continued From page 12 2/2/11 at 3:25 PM the IC Nurse stated she had knowledge of 5 MRSA cases related to post-op infections presenting to the ED but was unable to verify if these surgeries were performed in-house or performed at another facility. The IC Nurse was unable to provide QAPI documents that measured, analyzed, and tracked quality indicators related to MRSA infections in the facility.	A 275	A275, 2 cont'd This process was changed to the above mentioned in January of 2011. In addition, positive cultures and antibiotic appropriateness are submitted at the quarterly Department of Emergency Medicine Committee. This meeting was held on March 1, 2011 and the meeting minutes reflect this report. 3. This deficiency will be corrected by Infection Control providing a monthly tracking and trending report to the Executive Director of emergency services. This report lists any positive MRSA cultures collected in the Emergency Department, as well as source of the organism and, antibiotic appropriateness. Surgical site infections are also tracked for in-house versus surgeries performed at other facilities. Infection Control tracks and trends all MRSA positive screens and cultures facility wide for source, appropriate PPE usage, and isolation. This deficiency was corrected at the quarterly Department of Emergency Medicine Committee held on March 1, 2011. Ongoing compliance will be monitored by the ED MRSA tracking report being presented to the Infection Control Committee, which meets every other month. Any trends identified will be reported to the Medical Executive Committee which meets monthly. Emergency Department specific data was presented at the March 2011 Department of Emergency Medicine Committee and at the March 14, 2011 Infection Control Committee. Ongoing compliance will be monitored by review of the meeting minutes of this committee by Quality Outcomes Staff.	3/1/11
A 276	482.21(b)(2)(ii) QAPI IDENTIFY IMPROVEMENT [The hospital must use the data collected to--] (ii) Identify opportunities for improvement and changes that will lead to improvement. This STANDARD is not met as evidenced by: Based on review of policy, ED Committee Minutes and interview, it was determined the facility failed to provide QAPI documents that used data collected to identify opportunities for improvement and changes that would lead to improvement. The findings include: 1. The facility policy "Quality+ Plan for Improving Organizational Performance," documented as objectives on page 2, "...establishing quality improvement priorities and principles...analyzing their own processes and effectiveness...". 2. ED Committee Minutes for 9/7/10 on page 2 documented a medical director's concern for "...a few cases of patients who have come back with surgical site infections," and sent home with antibiotics which, "may or may not work due to the MRSA situation."	A 276	A276 1. The hospital has reviewed the policy on Quality Plus Plan for Improving Organizational Performance. Data collected will be used to identify opportunities for improvement and changes that will lead to improvement. 2. The MRSA "situation" referred to was a reference to the prevalence of MRSA colonization in the community. He was not referring to a MRSA "situation" in the hospital. JMCGH has a robust screening and isolation policy for MRSA. In order to follow up on appropriate antibiotic usage, an electronic power form "Culture Physician Follow Up" was created in January 2011. Positive cultures collected in the Emergency Department are called to the charge nurse, when (cont'd)	2/8/11 3/1/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 276	Continued From page 13 2. During an interview in the conference room on 2/2/11 at 3:25 PM the IC Nurse stated she had knowledge of 5 MRSA cases related to post-op infections presenting to the ED but was unable to provide QAPI documents used to identify opportunities for improvement and changes related to MRSA infections in the facility.	A 276	A276, 2 cont'd final results including susceptibility are received the Emergency Room Physician is notified and, the chart is reviewed for appropriate antibiotics and treatment. Staff will document the MD who reviews the results as well as any additional comments. Ongoing compliance will be monitored by review of all positive cultures being received by the Head Clinical Records Specialist for follow up documentation with Emergency Department physician and the patient when applicable. This process was changed to the above mentioned in January of 2011. In addition, positive cultures and antibiotic appropriateness are submitted at the quarterly Department of Emergency Medicine Committee. This meeting was held on March 1, 2011 and the meeting minutes reflect this report.	
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on medical record review and interview, it was determined the hospital failed to ensure a care plan was developed for 1 (Patient #15) of 44 sampled patients reviewed. The findings included: 1. Medical record review for Patient #15 documented an admission date of 1/24/11 with a PEG tube in place on admission. Review of the care plan documented the care plan was developed on 1/24/11 with no documentation of the PEG tube until 1/31/11. 2. During an interview with Nurse #4, in the classroom of floor B3 on 1/31/11 at 11:30 AM, Nurse #4 confirmed Patient #15 did have a PEG tube on admission and the Peg Tube was not included in the care plan on admission.	A 396	3. This deficiency will be corrected by Infection Control providing a monthly tracking and trending report to the Executive Director of emergency services. This report lists any positive MRSA cultures collected in the Emergency Department, as well as source of the organism and antibiotic appropriateness. Surgical site infections are also tracked for in-house versus surgeries performed at other facilities. Infection Control tracks and trends all MRSA positive screens and cultures facility wide for source, appropriate PPE usage, and isolation. This deficiency was corrected at the quarterly Department of Emergency Medicine Committee held on March 1, 2011. The ED MRSA data will be reported to the Infection Control Committee, composed of Infection Control Staff, Infectious Disease physicians, other specialty physicians and hospital leadership, every other month. Any trends identified are reported to the Medical Executive Committee which meets monthly. Emergency Department specific data was presented at the March 2011 Department of Emergency Medicine Committee and at the March 14, 2011 Infection Control Committee meeting. Ongoing compliance will be monitored by review of the meeting minutes of this committee by Quality Outcomes Staff	3/1/11
A 406	482.23(c)(2) WRITTEN MEDICAL ORDERS FOR DRUGS With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved	A 406	A396 1. The Chief Nursing Officer is responsible for corrective action to ensure that a care plan is developed for every patient. This deficiency will be corrected by the CNO and Floor/Unit Directors educating all nursing staff that 1) all patients must have an accurate and complete care plan in their medical record. Care plans must be updated with pertinent patient care information every 12 hours and all patient interventions and problems are listed on the care plan. This education was was completed on 3/9/11. Care plans are monitored by individual nursing units at the end of shift chart check. All new nursing employees will receive appropriate care plan development and maintenance education during new nurse orientation. Care plan competencies will be re-assessed during the mandatory annual skills fair.	3/9/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 406	Continued From page 14 hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under §482.12(c). This STANDARD is not met as evidenced by: Based on medical record review, Medical staff Rules and Regulations review and interview, it was determined the facility failed to ensure all orders for medications were written and signed by practitioners authorized by hospital policy for 2 of 44 (Patients #4 and 24) sampled patients. The findings included: 1. Medical record review for Patient #4 revealed: Medication order dated 1/18/11 documented, "0815, Decrease Vancomycin to 1.25 g IV q 12 hrs. Next dose @ 1800 today." This order was signed with Physician's name/Pharm D #1. Medication order dated 1/21/11 documented, "0845, (1) hold vancomycin...(3) if level results < 20.0, start Vancomycin 1250 mg IVPB Q 24." This order was signed with Physician's name/Pharm D #2. Medication order dated 1/22/11 documented, "1235, Go ahead and start Vanc 1250 mg IV Q 24 start now please." This order was signed with Physician's name/Pharm D #3. A medication order dated 1/26/11 documented, "1245, Change Vancomycin ^ 1.5 g IV Q 24 c next dose due at 1300 1/27/11." This order was signed with Physician's name/Pharm D #4. 2. Medical record review for Patient #24 revealed:	A 406	A396 2. The Chief Nursing Officer is responsible for corrective action to ensure that a care plan is developed for every patient. This deficiency will be corrected by the CNO and Floor/Unit Directors educating all nursing staff that 1) all patients must have an accurate and complete care plan in their medical record. Care plans must be updated with pertinent patient care information every 12 hours and all patient interventions and problems are listed on the care plan. This education was was completed on 3/9/11. Care plans are monitored by individual nursing units at the end of shift chart check. All new nursing employees will receive appropriate care plan development and maintenance education during new nurse orientation. Care plan competencies will be re-assessed during the mandatory annual skills fair. A406 This process was previously approved by Pharmacy and Therapeutics and Med Exec Committees but failed to get changed in the Rules & Regs as intended by the Medical Staff. 1. To ensure all orders for medications are written and signed by practitioners authorized by hospital policy, a proposed revision to the Medical Staff Rules and Regulations was presented at the Medical Executive Committee on 3/14/11. The revision will be presented at the Board of Trustees meeting on 3/29/11 for approval. This revision will allow pharmacists to write/change orders per protocols previously approved by the Pharmacy and Therapeutics committee and the Medical Staff. The Chief Medical Officer is responsible for this corrective action. Health Information Management will monitor patient records for appropriate documentation of written orders per Medical Staff Rules and Regulations with results reported monthly to the Patient Care Committee of the Medical Staff. 2. To ensure all orders for medications are written and signed by practitioners authorized by hospital policy, a proposed revision to the Medical Staff Rules and Regulations was presented at the Medical Executive Committee on 3/14/11. The revision will be presented at the Board of Trustees meeting on 3/29/11 for approval. This revision will allow pharmacists to write/change orders per protocols approved by the Pharmacy and Therapeutics committee and the Medical Staff. The Chief Medical Officer is responsible for this corrective action. Health Information Management will monitor patient records for appropriate documentation of written orders per Medical Staff Rules and Regulations with results reported monthly to the Patient Care Committee of the Medical Staff.	3/9/11 3/29/11 3/29/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440002	A. BUILDING _____ B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON-MADISON COUNTY GENERAL HOSPITAL	620 SKYLINE DRIVE JACKSON, TN 38301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 406	Continued From page 15 A medication order dated 1/28/11 documented, "0930, Change IV Protonix to Prevacid 30 mg Solutab PT daily @ next dose. Per P & T Protocol/Pharm D #1." 3. Medical staff "Rules and Regulations, Approved on 7/27/10...Diagnostic and Therapeutic Orders" documented, "Persons Authorized to Give Orders: Orders are to be given for patients...by those individuals who have been granted practice privileges, including physician/oral surgeon members of the medical staff, licensed independent affiliates, as defined in the Medical Staff Bylaws, CRNA, CNM, or Neonatal-ICU Nurse Practitioners (Authorized Persons)." 4. In an interview on 1/31/11 at 3:05 PM at the nurse's desk in the SICU, the Director of SICU stated, "The physicians tag the PharmD to dose Vancomycin and Gentamycin. It's a protocol and I've never seen a physician co-sign their orders." In an interview on 1/31/11 at 5:25 PM, the facility's Director of Nursing stated, "They (PharmDs) can sign orders. If they write v.o., the orders have to be authenticated." 5. There was no documentation available for review to document the Medical Staff had granted privileges for Doctors of Pharmacy to write medication orders, therefore any orders written by the PharmDs, according to the P&T protocols, were not legal orders authorized by the Medical staff.	A 406	A406 3. To ensure all orders for medications are written and signed by practitioners authorized by hospital policy, a proposed revision to the Medical Staff Rules and Regulations was presented at the Medical Executive Committee on 3/14/11. The revision will be presented at the Board of Trustees meeting on 3/29/11 for approval. This revision will allow pharmacists to write/change orders per protocols approved by the Pharmacy and Therapeutics committee and the Medical Staff. The Chief Medical Officer is responsible for this corrective action. Health Information Management will monitor patient records for appropriate documentation of written orders per Medical Staff Rules and Regulations with results reported monthly to the Patient Care Committee of the Medical Staff. 4. To ensure all orders for medications are written and signed by practitioners authorized by hospital policy, a proposed revision to the Medical Staff Rules and Regulations was presented at the Medical Executive Committee on 3/14/11. The revision will be presented at the Board of Trustees meeting on 3/29/11 for approval. This revision will allow pharmacists to write/change orders per protocols approved by the Pharmacy and Therapeutics committee and the Medical Staff. The Chief Medical Officer is responsible for this corrective action. Health Information Management will monitor patient records for appropriate documentation of written orders per Medical Staff Rules and Regulations with results reported monthly to the Patient Care Committee of the Medical Staff. 5. To ensure all orders for medications are written and signed by practitioners authorized by hospital policy, a proposed revision to the Medical Staff Rules and Regulations was presented at the Medical Executive Committee on 3/14/11. The revision will be presented at the Board of Trustees meeting on 3/29/11 for approval. This revision will allow pharmacists to write/change orders per protocols approved by the Pharmacy and Therapeutics committee and the Medical Staff. The Chief Medical Officer is responsible for this corrective action Health Information Management will monitor patient records for appropriate documentation of written orders per Medical Staff Rules and Regulations with results reported monthly to the Patient Care Committee of the Medical Staff.	3/29/11 3/29/11 3/29/11
A 457	482.24(c)(1)(iii) VERBAL ORDERS AUTHENTICATED BASED ON LAW All verbal orders must be authenticated based	A 457		

The Joint Commission

SUPPLEMENTAL #1
October 29, 2015
10:16 am

Jackson-Madison County General Hospital
620 Skyline Drive
Jackson, TN 38301

Organization Identification Number: 4717

Program(s)	**Survey Date(s)**
Hospital Accreditation Home Care Accreditation	10/21/2013-10/25/2013

Executive Summary

Hospital Accreditation :

As a result of the accreditation activity conducted on the above date(s), you have met the criteria for Accreditation with Follow-up Survey.

You will have follow-up in the area(s) indicated below:

- As a result of a Condition Level Deficiency, an Unannounced Medicare Deficiency Follow-up Survey will occur. Please address and correct any Condition Level Deficiencies immediately, as the follow-up event addressing these deficiencies will occur within 45 days of the last survey date identified above. The follow-up event is in addition to the written Evidence of Standards Compliance response.
- Evidence of Standards Compliance (ESC)

Home Care Accreditation :

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP7
	EC.02.05.05	EP4
	IC.02.02.01	EP1,EP2
	LS.02.01.20	EP1
	MM.04.01.01	EP13
	NPSG.03.04.01	EP5
	PC.01.03.01	EP1
	PC.02.01.03	EP7
	PC.03.01.03	EP1
Program:	Home Care Accreditation Program	
Standards:	EQ.01.03.01	EP5
	NPSG.03.06.01	EP3
	NPSG.15.02.01	EP1
	PC.01.02.03	EP3
	PC.02.01.01	EP1
	RC.02.01.01	EP2

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.03.05	EP9
	EC.02.06.01	EP13
	LD.01.03.01	EP2
	LD.04.01.05	EP4
	LS.02.01.10	EP4
	PC.01.02.03	EP4,EP8
	RI.01.03.01	EP13

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

	RI.01.05.01	EP4
	TS.03.01.01	EP7
	UP.01.03.01	EP2
Program:	Home Care Accreditation Program	
Standards:	EQ.02.01.01	EP1
	HR.01.02.05	EP1
	PC.01.03.01	EP5

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(b)(3)	A-0132	HAP - RI.01.05.01/EP4	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)(3)	A-0406	HAP - MM.04.01.01/EP13	Standard
§482.23(b)(4)	A-0396	HAP - PC.01.03.01/EP1	Standard
§482.23(c)	A-0405	HAP - PC.02.01.03/EP7	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(4)(i)(A)	A-0458	HAP - PC.01.02.03/EP4	Standard

CoP: §482.26 **Tag:** A-0528 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.26 Condition of Participation: Radiologic Services

The hospital must maintain, or have available, diagnostic radiologic services. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.

CoP Standard	Tag	Corresponds to	Deficiency
§482.26(b)(1)	A-0536	HAP - EC.02.02.01/EP7	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Condition

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(4)	A-0726	HAP - EC.02.06.01/EP13	Standard
§482.41(b)(1)(i)	A-0710	HAP - EC.02.03.05/EP9, LS.02.01.10/EP4, LS.02.01.20/EP1	Standard
§482.41(c)(2)	A-0724	HAP - EC.02.05.05/EP4	Standard

CoP: §482.42 **Tag:** A-0747 **Deficiency:** Condition

Corresponds to: HAP - IC.02.02.01/EP1, EP2

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)(2)	A-0955	HAP - RI.01.03.01/EP13	Standard
§482.51(b)(1)(i)	A-0952	HAP - PC.01.02.03/EP4	Standard
§482.51(b)	A-0951	HAP - IC.02.02.01/EP2	Standard

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Condition

Corresponds to: HAP - LD.01.03.01/EP2

Text: §482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. The governing body (or the persons legally responsible for the conduct of the hospital and carrying out the functions specified in this part that pertain to the governing body) must include a member, or members, of the hospital's medical staff.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01

ESC 45 days

Standard Text: The hospital manages risks related to hazardous materials and waste.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

7. The hospital minimizes risks associated with selecting and using hazardous energy sources.
Note: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs).

3

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 7
§482.26(b)(1) - (A-0536) - (1) Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
A lead apron in the EP lab was not on the unit's inventory and it could not be verified that it had received an annual inspection, as required by hospital policy.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.05

ESC 60 days

Standard Text: The hospital maintains fire safety equipment and fire safety building features.
Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

9. For automatic sprinkler systems: Every 12 months, the hospital tests main drains at system low point or at all system risers. The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 25, 1998 edition (Section 9-2.6).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 9
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During the document review session it was noted that various elements associated with this standard (main drain) were completed, however the number of seconds for the residual pressure to return to normal during the test was not documented.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.05.05

ESC 45 days

Standard Text: The hospital inspects, tests, and maintains utility systems.
Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. The hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. These activities are documented. (See also EC.02.05.01, EPs 2-4)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at West Tennessee Surgery Center (700 W. Forest Ave., Suite 100, Jackson, TN) site for the Hospital deemed service.
In tracer activity ,discussion with the staff, and in document review it was discovered that in the sterile processing at West Tennessee Surgery Center that appropriate pressure relationships and air exchanges were not preformed or documented between the sterile process area and the corridors. The tissue test revealed that the room was negative to the hallways and corridors.

Observed in Building Tour at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During the document review session, building tour, and staff interviews it was noted that the organization has a Ventilation/Room Pressure Relationships which was updated on 01/12/2010 that they will monitored the various required areas per F.G.I guidelines. However, no documentation exists that air flows and air exchanges were monitored per organization policy. This includes all 25 OR Rooms, 6 Cath Rooms, endoscopies, bronchoscopies, OB, and Central Sterile.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.06.01 ESC 60 days

Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

13. The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided. 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

SUPPLEMENTAL #1
October 29, 2015
10:16 am

EP 13
§482.41(c)(4) - (A-0726) - (4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at West Tennessee Surgery Center (700 W. Forest Ave., Suite 100, Jackson, TN) site for the Hospital deemed service.
In discussion with the staff and document review it was noted that humidity levels have not been recorded or documented in the sterile process area at West Tennessee Surgery Center. This observation was corrected on site and currently the area is being monitored for humidity levels.

Observed in Building Tour at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During the document review session, building tour, and staff interviews it was noted that the organization recently started to monitored humidity and temperature in the OR (May 2013) and Central Sterile (10-23-13). However, in the OR area the daily log showed a multiples times during the past 6 months where the temperature was less than 68F (as low as 58F) and the corresponding humidity readings were above 60F (as high as 71F).

Chapter:	Infection Prevention and Control
Program:	Hospital Accreditation
Standard:	IC.02.02.01 ESC 45 days
Standard Text:	The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.
Primary Priority Focus Area:	Infection Control

The Joint Commission Findings

Element(s) of Performance:

1. The hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment, devices, and supplies. *
Note: Low-level disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions.
Footnote *: For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Sterilization and Disinfection in Healthcare Settings).

Scoring Category : C
Score : Partial Compliance

2. The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)
Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Standard is NOT MET as evidenced by:
Observed in Tracer Activities at Sports Plus Dyersburg (177 Woodlawn Avenue, Dyersburg, TN) site for the Hospital deemed service.
A Physical Therapy treatment table was found with five holes in the mat. Therefore, the pad could not be disinfected appropriately.

Observed in Tracer Activities at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
The Mold Room in the Radiation Oncology Suite was extremely dirty and dusty. It was apparent the floors, counters and equipment had not been cleaned on a routine basis. The Director stated that some of the equipment and molds were not used any longer but they did use the room on occasion.

EP 2
§482.42 - (A-0747) - §482.42 Condition of Participation: Condition of Participation: Infection Control
This Condition is NOT MET as evidenced by:
Observed in Individual Tracer at West Tennessee Surgery Center (700 W. Forest Ave., Suite 100, Jackson, TN) site for the Hospital deemed service.
During tracer activity and in discussion with the staff it was discovered that when a surgical instrument requires immediate use sterilization, the equipment is cleaned by the nursing staff prior to being placed in the sterilizer. The staff did not know the required time and procedures for cleaning and disinfection processes that are required by AAMI and CDC guidelines prior to immediate use sterilization. During the survey, the hospital changed the policy to have all dropped instruments requiring immediate use sterilization to be taken to the decontamination area for processing before immediate use sterilization. The hospital initiated training for all staff to apply this revised policy during the survey.

Observed in Tracer Activities at West Tennessee Surgery Center (700 W. Forest Ave., Suite 100, Jackson, TN) site for the Hospital deemed service.
In discussion with the staff in the sterile processing area it was observed that the Sterrad Unit used in a sterilization of surgical equipment contains a vapor plate. As per the recommendations from the manufacturer, these plates need to be cleaned at least once monthly and as needed. There was not any documentation that this was preformed as required by the manufacturer. There organization updated their policy during the survey to reflect the manufacturer's recommendations and developed a log to monitor the cleaning process.

§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During a tracer in the OR, it was observed that biologic indicators and controls were performed for immediate use sterilizers without documenting the lot numbers of the tests performed. The lot numbers were documented for the BIs and controls in the Sterile Processing Department. During the survey, the process in the OR was modified and new documentation forms created to have the BIs and control lot numbers recorded for all tests of function status of immediate use sterilizers.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During a tracer in the Bronchoscopy Suite, it was observed that the RT cleaned the contaminated bronchoscope in a sink in the procedure room where the patient was being recovered from her procedure. The RT donned gloves to clean the scope without any facial PPE or other apron to protect her uniform that she wore to other patient care areas. The unit policy for cleaning the scope did not require PPE to protect the staff face or uniform to prevent contamination from the materials on and in the scope that was being cleaned.

Program: Hospital Accreditation

Standard: LD.01.03.01 ESC 60 days

Standard Text: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Primary Priority Focus Area: Communication

Element(s) of Performance:

2. The governing body provides for organization management and planning. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.12 - (A-0043) - §482.12 Condition of Participation: Condition of Participation: Governing Body
This Condition is NOT MET as evidenced by:
Observed in Auto Score for CLD at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site. The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews:§482.41 - (A-0700), §482.42 - (A-0747), §482.12 - (A-0043)

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.01.05 ESC 60 days

Standard Text: The hospital effectively manages its programs, services, sites, or departments.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. Staff are held accountable for their responsibilities. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in Building Tour at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site. Leadership did not hold staff accountable regarding the various physical environment issues (air flows/exchanges and temperature/humidity) involving staff, infection control, medical staff and facilities.

Chapter: Life Safety

Program: Hospital Accreditation

The Joint Commission Findings

Standard: LS.02.01.10 ESC 60 days

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

4. Openings in 2-hour fire-rated walls are fire rated for 1 1/2 hours. (See also LS.02.01.20, EP 3; LS.02.01.30, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1) 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During the building tour it was observed a painted over 1 hour rated door frame label at 7C-ICU.

Observed in Building Tour at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During the building tour it was observed a painted over 1.5 hour rated door frame label at Stair 6-North.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20 ESC 45 days

Standard Text: The hospital maintains the integrity of the means of egress.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. Doors in a means of egress are unlocked in the direction of egress. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:
Observed in Surveyor review but corrected onsite pending acceptable Evidence of Standards Compliance at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During the building tour it was observed that one leaf of a 2 hour set of fire rated exit doors failed to operate during multiple attempts (frozen shut) at the 1st Floor Cath Lab Stair

---

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.04.01.01

Standard Text: Medication orders are clear and accurate.
Primary Priority Focus Area: Medication Management

Element(s) of Performance:

13. The hospital implements its policies for medication orders.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 13
§482.23(c)(3) - (A-0406) - (3) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with State law and hospital policy, and who is responsible for the care of the patient as specified under §482.12(c).
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
Two oral pain medications for moderate pain were ordered for a patient, with no other instructions about how to prioritize which medication to give first. Hospital policy prohibited duplicate orders for moderate pain and there was no clarification of these orders by Pharmacy, which was also required by hospital policy.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
The Mechanical Ventilation Order Set in the EMR contained double range orders for propofol. A range order for dose was allowed by hospital policy, but not a range order for frequency. The range for frequency was eliminated from the order set during the survey, however, the staff still need to be educated about the change.

Chapter: National Patient Safety Goals
Program: Hospital Accreditation
Standard: NPSG.03.04.01 ESC 45 days
Standard Text: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.
Note: Medication containers include syringes, medicine cups, and basins.
Primary Priority Focus Area: Medication Management
Element(s) of Performance:

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.
Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. 3

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site.
During a tracer in the OR, it was observed that the scrub nurse had drawn up a clear solution in a syringe lying on the sterile field that was not labeled. Upon inquiry she noted that the solution was Marcaine and labeled it at that time.

Chapter: National Patient Safety Goals
Program: Hospital Accreditation
Standard: UP.01.03.01 ESC 60 days

The Joint Commission Findings

Standard Text: A time-out is performed before the procedure.

Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

2. The time-out has the following characteristics:
- It is standardized, as defined by the hospital.
- It is initiated by a designated member of the team.
- It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site. A cardiologist and a scrub nurse were involved in gowning the physician during the time out for an EP lab patient. This activity during the time out was not in compliance with hospital policy.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.03

Standard Text: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

4. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 6; RC.02.01.03, EP 3)

Scoring Category : C
Score : Insufficient Compliance

8. The hospital completes a functional screening (when warranted by the patient's needs or condition) within 24 hours after inpatient admission. (See also PC.01.02.01, EP 2; RC.02.01.01, EP 2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 4
§482.24(c)(4)(i)(A) - (A-0458) - (A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site.
The History and Physical on a patient's record prior to a cardiac cath procedure did not contain documentation of a physical exam. Documentation of an exam is required by hospital policy.

§482.51(b)(1)(i) - (A-0952) - (i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During a tracer, it was observed that the surgeon had performed and H & P on 09/04 for an operation performed on 10/08. The surgeon had updated the H& P rather than conducting a new H & P as required.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During a tracer in the PACU, it was observed that the surgeon recorded an incomplete H & P on the day before the operation. The patient could not remember when she had seen the surgeon in his office.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During a tracer, it was observed that the surgeon did not record an H & P for 48 hours after an emergency admission and operation.

EP 8
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site.
There was no evidence in a patient record reviewed that a functional screening had been completed within the first 24 hours of the patient's admission.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site.
There was no documentation in a second record reviewed that a functional screening had been completed within 24 hours after inpatient admission. Discussion with staff reveals that some patient populations such as stroke and orthopedic, have PT referrals built into their order sets. There are no defined functional screening criteria which are applied to all inpatients within the first 24 hours of admission.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01

ESC 45 days

Standard Text: The hospital plans the patient's care.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also RC.02.01.01, EP 2)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
§482.23(b)(4) - (A-0396) - (4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During a patient tracer, it was observed that a patient was placed on contact precautions because treatment resistent e.coli was cultured from sacral and coccyx wounds. This problem was not addressed in the plan of care. Additionally, the primary focus of the patient's care involved end of life decisions and care. These end of life issues were also not addressed in the plan of care.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During a tracer, it was observed that the CAre Plan did not address removal of a Foley that had been indwelling for four days.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During a tracer, it was observed that the Care Plan did not address issues related to "leech therapy" for this thumb reimplantation patient.

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.02.01.03 ESC 45 days
Standard Text: The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.
Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

7. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 7
§482.23(c) - (A-0405) - (c) Standard: Preparation and administration of drugs.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
The computerized order for a propofol sedation drip did not specify a starting dose or the dose and rate of titration for a post CABG patient. The surveyor was presented with a nursing policy that nurses reported they used when titrating propofol, however, this policy had not gone through a full approval process which included medical and pharmacy staff, and the actual administration of the propofol drip did not comply with this policy. In fact, the first titration dose was twice what was allowed in the policy.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
A propofol titration order for a patient in the Cardiac ICU did not contain a starting dose or instructions for the dose and rate of titration. The surveyor was referred to the computerized Mechanical Ventilation Order Set, which contained complete medication orders for a propofol sedation drip, however, the physician did not select this order set for implementation by the nurse. The nurses proceeded with the medication administration without complete medication orders.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.03.01.03 ESC 45 days

Standard Text: The hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. (See also RC.02.01.01, EP 2)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site.
The pre-sedation assessment for a bone marrow biopsy patient did not contain a Mallampati score. Hospital policy required that an airway assessment be conducted utilizing a Mallampati scale.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01 ESC 60 days

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

The Joint Commission Findings

Primary Priority Focus Area: Rights & Ethics

Element(s) of Performance:

13. Informed consent is obtained in accordance with the hospital's policy and processes and, except in emergencies, prior to surgery. (See also RC.02.01.01, EP 4)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 13
Observed in Building Tour at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site.
Hospital policy required that physicians obtain and document informed consent for blood administration. There was no documentation of a discussion between a physician and a CICU patient or family about the risks, benefits, and alternatives of blood administration. There was only documentation of a nurse's witnessing a patient's signature on the informed consent document.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site.
The record of a second patient contained a witnessed informed consent for blood, but there was no documentation that a physician had discussed the risks, benefits and alternatives to blood administration as required by hospital policy.

§482.51(b)(2) - (A-0955) - (2) A properly executed informed consent form for the operation must be in the patient's chart before surgery, except in emergencies.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During a tracer, it was observed that the surgeon did not document the risks, benefits and alternatives discussion that was done with the patient. The hospital consent form had no documentation of the discussion of risks, benefits and alternatives discussed with the patient as required by hospital policy. The surgeon consent form from her office was not dated when the patient signed.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During review of a second surgical procedure, it was observed that the surgeon did not document discussion of the risks, benefits and alternatives of the proposed procedure as required by hospital policy.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During a tracer, it was observed that the surgeon did not document discussion of the Risks, benefits and alternatives to the procedure in his consult note or elsewhere in the medical record as required by hospital policy.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.05.01

ESC 60 days

Standard Text: The hospital addresses patient decisions about care, treatment, and services received at the end of life.

The Joint Commission Findings

Primary Priority Focus Area: Communication

Element(s) of Performance:

4. For outpatient hospital settings: The hospital's written advance directive policies specify whether the hospital will honor advance directives.
Note: It is up to the hospital to determine in which of its outpatient settings, if any, it will honor advance directives.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§482.13(b)(3) - (A-0132) - (3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates).
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site for the Hospital deemed service.
During tracer activities at the Dyersburg Sport Plus location, staff members could not address how advance directives are managed in the outpatient setting. The organizational policy regarding advance directives did not address how the organization would honor advance directives in the outpatient setting. The admitting/registration department standard operating procedures outlined the Advance Directive process for specific areas and stated that in the outpatient setting, a hospital one page policy would be given the patient along with a referral to Patient Relations. However, when the surveyor asked about the AD policy at other outpatient locations, staff members gave conflicting information about the process and/or policy.

Chapter: Transplant Safety
Program: Hospital Accreditation
Standard: TS.03.01.01

Standard Text: The hospital uses standardized procedures for managing tissues.
Primary Priority Focus Area: Information Management

Element(s) of Performance:

7. The hospital verifies at the time of receipt that package integrity is met and transport temperature range was controlled and acceptable for tissues requiring a controlled environment. This verification is documented. (See also TS.03.02.01, EP 6)
Note 1: If the distributor uses validated shipping containers, then the receiver may document that the shipping container was received undamaged and within the stated time frame.
Note 2: Tissues requiring no greater control than 'ambient temperature' (generally defined as the temperature of the immediate environment) for transport and storage would not need to have the temperature verified on receipt.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 7
Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site. During review of tissue implant logs, it was observed that the package integrity of the tissue was not documented at the time of receipt. Package integrity was documented at the time of implantation.

Observed in Individual Tracer at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site. During review of tissue processing log, it was observed that frozen ankle strut tissue package integrity was not verified at the time of receipt.

Observed in Document Review at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site. During review of tissue receipt logs, it was observed that the package integrity of bone putty was not verified at the time of receipt.

Chapter: Equipment Management
Program: Home Care Accreditation
Standard: EQ.01.03.01

Standard Text: The organization maintains, tests, and inspects the medical equipment it provides to patients.
Primary Priority Focus Area: Information Management
Element(s) of Performance:

5. The organization inspects medical equipment between use by different patients. The organization documents the performance of these inspections.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 5
Observed in Equipment management session at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site.
It was noted by the DME surveyor that items cleaned and tested by the service technicians did not have documented evidence of maintenance between patients. The items that were sent to bio med had documented maintenance but if the equipment checked out and did not need repair, it was not sent to biomed therefore it did not get documented. A sticker was placed on the bag over the equipment to indicate it was patient ready but the sticker was discarded at the time of delivery. In addition the sticker only indicated it was patient ready, not that it had been function tested. This process included items such as rental beds and rental wheelchairs. Because the organization serviced hospice, it did have a large amount of rental equipment in the warehouse. This situation was confirmed by the biomed technician and the warehouse manager.

Observed in Equipment maintenance session at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site.
For example, the DME surveyor noted that one rental bed in the warehouse purchased 2/2009 did not have any maintenance records at all. The warehouse manager confirmed this was true for all the rental beds, wheelchairs and other items checked between patients by the service technicians.

Chapter: Equipment Management

Program: Home Care Accreditation

Standard: EQ.02.01.01

ESC 60 days

Standard Text: The organization maintains, tests, and inspects medical equipment used by staff in the provision of care, treatment, or services.

Primary Priority Focus Area: Equipment Use

Element(s) of Performance:

1. The organization performs routine and preventive maintenance on medical equipment used by staff in the provision of care, treatment, or services at defined intervals and according to the manufacturers' guidelines. The organization documents the performance of these checks.
Note: If the manufacturer does not have guidelines for routine and/or preventive maintenance, the organization establishes such guidelines. For example, the organization may choose to have discussions with the manufacturer, observe its own failure rates for the equipment, examine maintenance schedules of like products, or use any other method that is effective.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
Observed in Equipment management session at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site.
The DME Surveyor identified that one apnea monitor simulator in the bio med repair area was past due for an annual calibration. The last calibration was 10/12/12. The bio med technician did not realize it was past due.

Observed in Equipment management session at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site.
The DME Surveyor noted that a second apnea monitor simulator observed in the bio med repair area was past due for an annual calibration. The last calibration was 9/21/12. The bio med technician did not realize it was past due.

Chapter: Human Resources

Program: Home Care Accreditation

Standard: HR.01.02.05

ESC 60 days

Standard Text: The organization verifies staff qualifications.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

1. When law or regulation requires care providers to be currently licensed, certified, or registered to practice their professions, the organization both verifies these credentials with the primary source and documents this verification when a provider is hired and when his or her credentials are renewed. (See also HR.01.02.07, EP 2)
Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. This verification is obtained from the appropriate state licensing or certification board, at the time of hire and at the time of renewal of credentials.
Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.
Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in HR File Review at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site.
When reviewing the personnel files, the DME surveyor was unable to see documented evidence that one ATP license was verified with the primary source. Verification was completed while the surveyor was on site.

Observed in HR File Review at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site.
When reviewing the personnel files, the DME surveyor was unable to see documented evidence that a second ATP license was verified with the primary source. Verification was completed while the surveyor was on site.

Chapter: National Patient Safety Goals

Program: Home Care Accreditation

Standard: NPSG.03.06.01 ESC 45 days

Standard Text: Maintain and communicate accurate patient medication information.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

3. Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies.
Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1) 3

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
Observed in Individual Tracer at Hospice of West Tennessee (1804 Highway 45 ByPass Suite 101, Jackson, TN) site. The organization failed to maintain and communicate accurate patient medication information. The medication list did not contain information on medications the patient was currently taking. The surveyor noted that the patient was taking Clonidine 0.1mg tablet orally as needed for elevated B/P. This medication was not on med list. Directions are to take 1/2 tab for B/P 180 systolic or . 100 diastolic. Date on bottle is 3/22/11. The wife stated that she had used this medication last week for elevated B/P. This was discussed with the Director.

Observed in Individual Tracer at Hospice of West Tennessee (1804 Highway 45 ByPass Suite 101, Jackson, TN) site. The organization failed to maintain and communicate accurate patient medication information. The medication list did not contain information on medications the patient was currently taking. The patient is currently taking Aleeve daily for pain, as reported by the daughter. Aleeve was not on the organization's med list. This was discussed with the Director.

Chapter: National Patient Safety Goals

Program: Home Care Accreditation

Standard: NPSG.15.02.01 ESC 45 days

Standard Text: Identify risks associated with home oxygen therapy such as home fires.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

1. Conduct a home oxygen safety risk assessment that addresses at least the following:
- Whether there are smoking materials in the home
- Whether there are other fire safety risks in the home, such as the potential for open flames
- Whether or not the home has functioning smoke detectors
Note: Further information about risks associated with home oxygen therapy and risk reduction strategies can be found in Sentinel Event Alert 17.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
Observed in Document Review at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site. While reviewing documents in an oxygen patient chart and documents in the new patient packet, the DME surveyor noted that the home assessment done upon set up of an oxygen patient, did not include the functional status of the smoke detector, smoking materials in the home, or the potential for open flames.

Observed in Individual Tracer at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site. While reviewing documents in an oxygen patient chart as well as a concentrator check done in the home, the DME surveyor noted that the home assessment did not include the functional status of the smoke detector, smoking materials in the home, or the potential for open flames.

Chapter: Provision of Care, Treatment, and Services
Program: Home Care Accreditation
Standard: PC.01.02.03

ESC 45 days

Standard Text: The organization assesses and reassesses the patient and his or her condition according to defined time frames.
Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

3. Each patient is reassessed as necessary based on his or her plan for care or changes in his or her condition.
Note: Reassessments may also be based on the patient's diagnosis; desire for care, treatment, or services; response to previous care, treatment, or services; and/or his or her setting requirements.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
Observed in Individual Tracer at Hospice of West Tennessee (1804 Highway 45 ByPass Suite 101, Jackson, TN) site. The organization failed to assess and reassess the patient according to defined time frames. Regulatory requirements and agency policy require the hospice aide to be supervised every 14 days by the RN. The organization failed to perform supervisory visits every 14 days. For example: Aide supervisory visits are not documented between 6/27/13 and 8/1/13. In addition, Supervisory visits were not documented between 8/1/13 and 8/22/13. This was discussed and confirmed with the Hospice Director.

Observed in Record Review at Hospice of West Tennessee (1804 Highway 45 ByPass Suite 101, Jackson, TN) site. The organization failed to assess and reassess the patient according to defined time frames. Regulatory requirements and agency policy require hospice aides to be supervised every 14 days by the RN. The organization failed to perform supervisory visits every 14 days. For example: Supervisory visits were done on 7/10/13 and on 7/25/13, this was one day late. Supervisory visits were done on 8/7/13 and 8/22/13, this was one day late. This was discussed and confirmed with the Hospice Director.

Chapter: Provision of Care, Treatment, and Services

Program: Home Care Accreditation

Standard: PC.01.03.01

ESC 60 days

Standard Text: The organization plans the patient's care.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

5. The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
Observed in Record Review at Hospice of West Tennessee (1804 Highway 45 ByPass Suite 101, Jackson, TN) site. The organization failed to plan the patient's care based on the patient's goals and time frames, settings, and services required to meet those goals. Review of the goals identified on the hospice interdisciplinary plans of care revealed that the goals were not individualized and there were no measurable time frames set in which to base the written plan of care required to safely meet patient needs. For example, the goal for pain management was to "achieve and maintain optimal pain control." Individual interventions are not dated and there are no time frames to accomplish the goal. Discipline-specific goals were also not
consistently identified. A discussion was held with the Director on writing goals and individualizing plans.

Chapter: Provision of Care, Treatment, and Services

Program: Home Care Accreditation

Standard: PC.02.01.01

ESC 45 days

Standard Text: The organization provides care, treatment, or services for each patient.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

1. The organization provides the patient with care, treatment, or services according to his or her individualized plan of care.

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
Observed in Individual Tracer at Hospice of West Tennessee (1804 Highway 45 ByPass Suite 101, Jackson, TN) site. During home visit #2 and subsequent clinical record review, it was noted that the home health aide did not follow the patient's individualized plan of care as assigned by the registered nurse. Example: The home health aide care plan prepared by the registered nurse did not include shampooing the patient's hair. The home health aide documented shampooing the patient's hair on 13 visits. This was discussed and confirmed with the Hospice Director.

Observed in Record Review at Jackson-Madison County General Hospital (620 Skyline Drive, Jackson, TN) site. During clinical record review #3, it was noted that the home health aide did not follow the patient's individualized plan of care as assigned by the registered nurse. Example: The home health aide care plan prepared by the registered nurse included shampooing the patient's hair. The home health aide did not document shampooing the patient's hair on more than 20 visits. There was not a notation of refusal of shampoo. This was discussed and confirmed with the Hospice Director.

Chapter: Record of Care, Treatment, and Services

Program: Home Care Accreditation

Standard: RC.02.01.01

ESC 45 days

Standard Text: The patient record contains information that reflects the patient's care, treatment, or services.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

2. The patient record contains the following clinical information:
- Any medications administered, including dose
- Any activity restrictions
- Any changes in the patient's condition
- Any summaries of the patient's care, treatment, or services furnished to the patient's physician or licensed independent practitioner(s)
- The patient's medical history
- Any allergies or sensitivities
- Any adverse drug reactions
- The patient's functional status
- Any diet information or any dietary restrictions
- Diagnostic and therapeutic tests, procedures, and treatments, and their results
- Any specific notes on care, treatment, or services
- The patient's response to care, treatment, or services
- Any assessments relevant to care, treatment, or services
- Physician orders
- Any information required by organization policy, in accordance with law and regulation
- A list of medications, including dose, frequency, and route of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services
- The plan of care
- For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician. (See also PC.01.02.01, EP 1; PC.01.03.01, EPs 1 and 23)

Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document.
Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Individual Tracer at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site. During individual tracer activity, pharmacist surveyor identified that four of six medications on the patient's medication profile lacked the correct dose of the medication.

Observed in Individual Tracer at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site. During individual tracer activity for a second patient, pharmacist surveyor identified that two medications on the patient's medication profile lacked the correct dose of the medication.

Observed in Individual Tracer at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site. During observation of a clinical respiratory patient the DME surveyor noted there was a medication profile on the discharge orders but also noted that the therapist did not discuss the medication profile with the patient. The RT manager and the Homecare Director stated that it was not part of the process to discuss the list with the patient. Therefore, it was not known if the list was current or accurate, or if the patient was compliant with the use of the medications.

Observed in Record Review at Medical Center Medical Products (1061 West Forest Ave, Jackson, TN) site. The DME surveyor noted that this process of not reviewing the medication profile with the patient was consistent with all clinical respiratory patients.

---

carf INTERNATIONAL

January 23, 2014

Tim Adams
West Tennessee Rehabilitation Center
620 Skyline Drive, 4th Floor
Jackson, TN 38301

Dear Mr. Adams:

It is my pleasure to inform you that West Tennessee Rehabilitation Center has been accredited by CARF International for a period of three years for the following programs:

Inpatient Rehabilitation Programs - Hospital (Adults)
Inpatient Rehabilitation Programs - Hospital (Children and Adolescents)
Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)

This accreditation will extend through December 2016. This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of practice excellence.

Your organization should take pride in achieving this high level of accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation, and we encourage you to make this accomplishment known throughout your community. Communication of the accreditation to your referral and funding sources, the media, and local and federal government officials can promote and distinguish your organization. Enclosed are some materials that will help you publicize this achievement.

The survey report is intended to support a continuation of the quality improvement of your programs. It contains comments on your organization's strengths as well as suggestions and recommendations. A quality improvement plan (QIP) demonstrating your efforts to implement the survey recommendations must be submitted within the next 90 days to retain accreditation. Guidelines and the form for completing the QIP have been posted on Customer Connect *(customerconnect.carf.org),* our secure, dedicated website for accredited organizations and organizations seeking accreditation. Please submit the QIP to the attention of the customer service unit identified in the QIP instructions.

Your organization's complimentary accreditation certificate will be sent separately. You may use the enclosed form to order additional certificates.

If you have any questions regarding your organization's accreditation, you are encouraged to seek support from a Resource Specialist in your customer service unit by calling extension 7174.

CARF INTERNATIONAL
6951 East Southpoint Road
Tucson, AZ 85756 USA
Toll-free 888 281 6531
Tel/TTY 520 325 1044
Fax 520 318 1129

CARF-CCAC
1730 Rhode Island Avenue, NW, Suite 410
Washington, DC 20036 USA
Toll-free 866 888 1122
Tel 202 587 5001
Fax 202 587 5009

CARF CANADA
10665 Jasper Avenue, Suite 760
Edmonton, AB T5J 3S9 CANADA
Toll-free 877 434 5444
Tel 780 429 2538
Fax 780 426 7274

We encourage your organization to continue fully and productively using the CARF standards as part of your ongoing commitment to accreditation. We commend your commitment and consistent efforts to improve the quality of your programs. We look forward to working with your organization in the future.

Sincerely,

Brian J. Boon, Ph.D.
President/CEO

aw
Enclosures

SUPPLEMENTAL #1

October 29, 2015
10:16 am

carf INTERNATIONAL

Three-Year Accreditation

CARF Survey Report for West Tennessee Rehabilitation Center

CARF INTERNATIONAL
6951 East Southpoint Road
Tucson, AZ 85756 USA
Toll-free 888 281 6531
Tel/TTY 520 325 1044
Fax 520 318 1129

CARF-CCAC
1730 Rhode Island Avenue, NW, Suite 410
Washington, DC 20036 USA
Toll-free 866 888 1122
Tel 202 587 5001
Fax 202 587 5009

CARF CANADA
10665 Jasper Avenue, Suite 760
Edmonton, AB T5J 3S9 CANADA
Toll-free 877 434 5444
Tel 780 429 2538
Fax 780 426 7274

SUPPLEMENTAL #1
October 29, 2015
10:16 am

carf INTERNATIONAL

Three-Year Accreditation

Organization

West Tennessee Rehabilitation Center (WTRC)
620 Skyline Drive, 4th Floor
Jackson, TN 38301

Organizational Leadership

Davidson Curwen, M.D., Medical Director

Tim Adams, Executive Director

Julie Taylor, PT, Program Director

Survey Dates

November 21-22, 2013

Survey Team

Dani C. Kinch, Administrative Surveyor

Elizabeth Matalon, M.B.A., PT, Program Surveyor

Programs/Services Surveyed

Inpatient Rehabilitation Programs - Hospital (Adults)
Inpatient Rehabilitation Programs - Hospital (Children and Adolescents)
Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)

Previous Survey

November 8-9, 2010
Three-Year Accreditation

Survey Outcome

Three-Year Accreditation
Expiration: December 2016

CARF INTERNATIONAL
6951 East Southpoint Road
Tucson, AZ 85756 USA
Toll-free 888 281 6531
Tel/TTY 520 325 1044
Fax 520 318 1129

CARF-CCAC
1730 Rhode Island Avenue, NW, Suite 410
Washington, DC 20036 USA
Toll-free 866 888 1122
Tel 202 587 5001
Fax 202 587 5009

CARF CANADA
10665 Jasper Avenue, Suite 760
Edmonton, AB T5J 3S9 CANADA
Toll-free 877 434 5444
Tel 780 429 2538
Fax 780 426 7274

SURVEY SUMMARY

West Tennessee Rehabilitation Center (WTRC) has strengths in many areas.

- WTRC enjoys an excellent and well-deserved reputation for the provision of quality rehabilitation services. The positive comments received from patients and other stakeholders testify to the strength of its reputation.
- The leadership and clinical personnel are dedicated and enthusiastic about the services they provide, and mutual respect is evident. This has promoted strong loyalties to the organization and longstanding employment relationships that continue to remain focused on quality improvement initiatives.
- The program director of the WTRC is a recognized leader who has a plan for the development of the rehabilitation department and programs in the WTRC network that is strategic and well thought out and balances the needs of the patients and personnel. Although the department has undergone a significant amount of organizational change in the last two years, the program director's leadership during this period has resulted in great successes. Changes made within the department utilize a business model for service delivery in inpatient rehabilitation that meets the business needs of WTRC and the community and is established in such a way as to ensure sustainability with the program model.
- RehabCare® has committed intake coordination resources to assist WTRC in decreasing service access barriers, resulting in a significant increase in census in 2013 and increasing service access beyond the West Tennessee Healthcare system to the greater Western Tennessee community. This process has also greatly improved the responsiveness of acceptance into the programs.
- The medical director is experienced and committed to the ongoing success of the inpatient rehabilitation programs. The medical director's support coupled with the operational changes implemented in 2013 has successfully increased access to services within West Tennessee communities.
- The risk management program is extensive with regard to incident reviews concerning falls. This review involves a medical review with a pharmacist to identify any potential pharmacological influences and consider any appropriate modification of medications to reduce the occurrence of falls.
- WTRC is commended for its active fundraising activities and the creation of the Humanitarian Fund to provide assistive devices and supplies for patients who are not able to fund these items themselves. The rehabilitation department initiates fundraising for colleagues and other community events on a regular basis, further demonstrating WTRC's support of the needs of the patients, personnel, and the greater community.
- WTRC is complimented for its use of the booklet, *Stroke Moving Forward,* as one of the methods for educating the persons served and their families about the secondary complications of stroke.

WTRC should seek improvement in the areas identified by the recommendations in the report. Consultation given does not indicate nonconformance to standards but is offered as a suggestion for further quality improvement.

On balance, WTRC has reaffirmed its commitment to conform to the CARF standards. The organization's leadership is committed to the provision of quality rehabilitation services and is strongly supportive of the rehabilitation programs and their continued success, development, and growth. The expertise and experience of the personnel, coupled with the addition of key administrative personnel has maintained an environment of teamwork while decreasing service access barriers and increasing intakes within the program to meet the community's needs. Opportunities for improvement exist in the areas of consistency in goal prioritization within the strategic plan, demonstration of specialty competencies of personnel, consistent testing of all emergency procedures, consistent written analysis of critical incidents and complaints, review and assessment of personnel performance evaluation goals, written analysis of denials of referrals, and development of education/training for adolescents. The organization demonstrates the capability and willingness to address the recommendations noted in this report.

West Tennessee Rehabilitation Center has earned a Three-Year Accreditation. The executive leadership, operational leadership, and department personnel are complimented for this achievement and their efforts to provide quality rehabilitation services. They are encouraged to continue to use the CARF standards and existing resources to provide valued rehabilitation services for the communities served.

SECTION 1. ASPIRE TO EXCELLENCE®

A. Leadership

Principle Statement

CARF-accredited organizations identify leadership that embraces the values of accountability and responsibility to the individual organization's stated mission. The leadership demonstrates corporate social responsibility.

Key Areas Addressed

- Leadership structure
- Leadership guidance
- Commitment to diversity
- Corporate responsibility
- Corporate compliance

Recommendations

A.5.a.(2)

The organization has a cultural competency and diversity plan that addresses its patient and other stakeholder audiences; however, it does not extend to its personnel. The organization is urged to implement a cultural competency and diversity plan that addresses its personnel.

A.6.b.(2)(a)

A.6.b.(2)(b)

It is recommended that the written procedures to deal with allegations of violations of ethical codes include time frames that are adequate for prompt decision making and result in timely decisions.

C. Strategic Planning

Principle Statement

CARF-accredited organizations establish a foundation for success through strategic planning focused on taking advantage of strengths and opportunities and addressing weaknesses and threats.

Key Areas Addressed

- Strategic planning considers stakeholder expectations and environmental impacts
- Written strategic plan sets goals
- Plan is implemented, shared, and kept relevant

Recommendations

C.2.c.(2)

The written strategic plan establishes goals and objectives. It is recommended that it also include priorities.

D. Input from Persons Served and Other Stakeholders

Principle Statement

CARF-accredited organizations continually focus on the expectations of the persons served and other stakeholders. The standards in this subsection direct the organization's focus to soliciting, collecting, analyzing, and using input from all stakeholders to create services that meet or exceed the expectations of the persons served, the community, and other stakeholders.

Key Areas Addressed

- Ongoing collection of information from a variety of sources
- Analysis and integration into business practices
- Leadership response to information collected

Recommendations

There are no recommendations in this area.

E. Legal Requirements

Principle Statement

CARF-accredited organizations comply with all legal and regulatory requirements.

Key Areas Addressed

- Compliance with all legal/regulatory requirements

Recommendations

There are no recommendations in this area.

F. Financial Planning and Management

Principle Statement

CARF-accredited organizations strive to be financially responsible and solvent, conducting fiscal management in a manner that supports their mission, values, and annual performance objectives. Fiscal practices adhere to established accounting principles and business practices. Fiscal management covers daily operational cost management and incorporates plans for long-term solvency.

Key Areas Addressed

- Budget(s) prepared, shared, and reflective of strategic planning
- Financial results reported/compared to budgeted performance
- Organization review
- Fiscal policies and procedures

- Review of service billing records and fee structure
- Financial review/audit
- Safeguarding funds of persons served

Recommendations

F.7.a. through F.7.b.(3)

Although the organization demonstrates a comprehensive billing audit process that is occurring quarterly as of this year, there was no evidence that reviews had been completed in the two previous years. The organization is urged to continue with the current quarterly billing audit process that documents that dates of services provided coincide with billed episodes of care, determines that the bills accurately reflect the services that were provided, and identifies the necessary corrective action.

G. Risk Management

Principle Statement

CARF-accredited organizations engage in a coordinated set of activities designed to control threats to their people, property, income, goodwill, and ability to accomplish goals.

Key Areas Addressed

- Identification of loss exposures
- Development of risk management plan
- Adequate insurance coverage

Recommendations

There are no recommendations in this area.

Consultation

- The organization and its overarching healthcare system have a comprehensive risk management plan. It is suggested that the WTRC consider developing its own freestanding risk management plan. This individualized plan could be themed in parallel with the greater healthcare system's risk management plan, but could offer the leadership of the inpatient rehabilitation departments specific items of varying levels of risk to services provided within their domain, allow it to maintain control over the action planning processes within the department(s), and integrate the risk management plan into the departmental strategic planning grid.

H. Health and Safety

Principle Statement

CARF-accredited organizations maintain healthy, safe, and clean environments that support quality services and minimize risk of harm to persons served, personnel, and other stakeholders.

Key Areas Addressed

- Inspections
- Emergency procedures
- Access to emergency first aid
- Competency of personnel in safety procedures
- Reporting/reviewing critical incidents
- Infection control

Recommendations

H.6.a.(1)

H.6.b. through H.6.d.

The organization described the process for unannounced tests of all emergency procedures and the process for analyzing for performance improvement resulting in improvement or affirmation of satisfactory practice; however, there was only written evidence for the last two years. It is recommended that the organization conduct unannounced tests of all emergency procedures at least annually on each shift and include complete actual or simulated physical evacuation drills. Tests should be analyzed for performance improvement that addresses areas needing improvement, actions to be taken, results of performance improvement plans, and necessary education and training of personnel. Tests should be evidenced in writing.

H.9.a. through H.9.b.(8)

A written analysis of all critical incidents was provided for the last two years. The organization is urged to consistently complete an annual written analysis of all critical incidents provided to or conducted by the leadership that addresses causes, trends, actions for improvement, results of performance improvement plans, necessary education and training of personnel, prevention of recurrence, internal reporting requirements, and external reporting requirements.

I. Human Resources

Principle Statement

CARF-accredited organizations demonstrate that they value their human resources. It should be evident that personnel are involved and engaged in the success of the organization and the persons they serve.

Key Areas Addressed

- Adequate staffing
- Verification of background/credentials
- Recruitment/retention efforts
- Personnel skills/characteristics
- Annual review of job descriptions/performance
- Policies regarding students/volunteers, if applicable

Recommendations

I.2.b.(2)

The organization has implemented a procedure that addresses time frames for verification of backgrounds and credentials including prior to the delivery of services to the persons served or to the organizations, and action to be taken in response to the information received concerning the results of the background checks. It is recommended that the written procedures also address time frames for verification of backgrounds throughout employment. This could include whether or not verification of backgrounds is conducted at any time throughout employment.

I.6.b.(4)(a)

Although the organization performs evaluations on personnel on an annual basis, the managers were only reviewing the previous year's goals as evidenced by a single checkmark on the performance review template. It is recommended that performance related to objectives established in the last evaluation period be assessed in subsequent evaluations. This might be accomplished by modifying the current performance evaluation tool to include an area to individually review the goals established in the previous evaluation period and indicate whether each goal was achieved, modified, or not completed.

J. Technology

Principle Statement

CARF-accredited organizations plan for the use of technology to support and advance effective and efficient service and business practices.

Key Areas Addressed

- Written technology and system plan

Recommendations

There are no recommendations in this area.

K. Rights of Persons Served

Principle Statement

CARF-accredited organizations protect and promote the rights of all persons served. This commitment guides the delivery of services and ongoing interactions with the persons served.

Key Areas Addressed

- Communication of rights
- Policies that promote rights
- Complaint, grievance, and appeals policy
- Annual review of complaints

Recommendations

K.5.a. through K.5.b.(3)

A written analysis of all formal complaints was available for the last two years. It is recommended that the organization complete an annual written analysis of all formal complaints that determines trends, areas needing performance improvement, and actions to be taken.

L. Accessibility

Principle Statement

CARF-accredited organizations promote accessibility and the removal of barriers for the persons served and other stakeholders.

Key Areas Addressed

- Written accessibility plan(s)
- Status report regarding removal of identified barriers
- Requests for reasonable accommodations

Recommendations

L.3.c.(1)

L.3.c.(2)

Although the organization was able to discuss progress made in the reduction or elimination of identified barriers to accessibility, it was not documented. It is recommended that the organization include within the written annual accessibility status report documentation of the progress made in the removal of identified barriers and the areas needing improvement.

Consultation

- It is suggested that the organization consider including the phrase "no barrier identified" in the annual accessibility plan update that could provide evidence of the areas reviewed as part of plan completion.
- WTRC uses the term *ongoing* frequently in its accessibility status report. It is suggested that the organization identify specific time lines for each barrier identified that could allow for a more focused action plan to reduce or eliminate each barrier identified.

M. Performance Measurement and Management

Principle Statement

CARF-accredited organizations are committed to continually improving their organizations and service delivery to the persons served. Data are collected and information is used to manage and improve service delivery.

Key Areas Addressed

- Information collection, use, and management
- Setting and measuring performance indicators

Recommendations

M.6.b.(4)(b)

It is recommended that the organization measure a service delivery performance indicator of satisfaction and feedback from other stakeholders.

M.7.a. through M.7.d.

When identifying a performance indicator of satisfaction and feedback from other stakeholders, the organization should determine to whom the indicator will be applied; the person(s) responsible for collecting the data; the source from which data will be collected; and a performance target based on an industry benchmark, based on the organization's performance history, or established by the organization or other stakeholder.

N. Performance Improvement

Principle Statement

The dynamic nature of continuous improvement in a CARF-accredited organization sets it apart from other organizations providing similar services. CARF-accredited organizations share and provide the persons served and other interested stakeholders with ongoing information about their actual performance as a business entity and their ability to achieve optimal outcomes for the persons served through their programs and services.

Key Areas Addressed

- Proactive performance improvement
- Performance information shared with all stakeholders

Recommendations

N.1.a.

N.1.b.(2)(d)(ii) through N.1.c.(3)

It is recommended that at least annually the organization analyze performance indicators in relation to established targets including satisfaction and feedback from other stakeholders and extenuating or influencing factors. The written analysis should identify areas needing performance improvement, result in an action plan to address improvements needed to reach established or revised performance targets, and outline actions taken or changes made to improve identified areas of improvement.

Consultation

- The organization is encouraged to consider modifying the materials contained within the first meeting handout provided to the patients to be more succinct. The organization might benefit from customizing this information by the demographic of each audience, such as the stroke specialty program or adolescent program.

SECTION 2. THE REHABILITATION AND SERVICE PROCESS FOR THE PERSONS SERVED

A. Program/Service Structure for All Medical Rehabilitation Programs

Key Areas Addressed

- Scope of the program and services
- Admission and transition/exit criteria
- Team communication
- Learning environment for personnel
- Analysis of denials, interrupted services, and ineligibility

---

Recommendations

A.11.c. through A.11.e.

WTRC has fostered a continuous learning environment for personnel by providing educational opportunities and programs that reflect differences in the learning styles, needs, and strengths of its rehabilitation personnel. It is recommended that the organization measure the satisfaction of personnel and the effectiveness of the learning opportunities, and address performance improvement as needed.

A.14.a. through A.14.c.
A.14.e.(1) through A.14.e.(2)

WTRC has conducted a review of denials and service referrals determined to be ineligible for admission for the current year; however, this was not evidenced for the previous two years. It is recommended that at least annually the organization conduct a written analysis of denials and service referrals determined to be ineligible. The analysis should address causes; trends; actions for improvement; results of performance improvement plans; and necessary education and training of personnel, payers, and regulatory agencies.

B. The Rehabilitation and Service Process for the Persons Served

Key Areas Addressed

- Scope of the program services
- Appropriate placement in and movement through the continuum of services
- Admission and ongoing assessments

- Information provided to persons served for decision making
- Team composition
- Team responsibilities and communication
- Medical director/physician providing medical input qualifications and responsibilities
- Discharge/transition planning and recommendations
- Family/support system involvement
- Education and training of persons served and families/support systems
- Sharing of outcomes information with the persons served
- Physical plant
- Records of the persons served

Recommendations

B.8.b.

An individualized written disclosure statement is provided to each patient that includes a predetermined amount of therapy time allotted. It is recommended that the intensity of services be individualized to reflect the patient's needs.

B.38.a.(1)
B.38.a.(8)

The information provided to the patients from the outcomes management system by the programs should include the characteristics of the patients served and unplanned transfers to acute medical facilities by relevant diagnostic category.

B.45.z.

The organization is urged to include in the patient record documentation of the location of any audiovisual records.

Consultation

- It is suggested that reducing duplication of information be a focus for the new software reporting template that is being developed. At present, for example, the separate evaluation templates for physical therapy, occupational therapy, and speech therapy all contain a section for patient history with the same information documented in each template.
- It is suggested that the patient record include documentation related to the achievement or nonachievement of outcomes within the anticipated time frames. This could help the programs be able to demonstrate that the patients make measurable progress toward accomplishment of their predicted outcomes within the time frames.

E. The Rehabilitation and Service Process for Children and Adolescents Served

Inpatient Rehabilitation Programs - Hospital

Key Areas Addressed

- Provision of services to any children/adolescents

Recommendations

E.6.d.(1)
E.6.d.(2)
E.6.g.
E.6.h.

WTRC provides care to adolescents on an inpatient basis. It is recommended that the rehabilitation staff that cares for adolescents demonstrate competencies that include sexuality, both normal development and after the onset of injury, illness, or impairment; setting boundaries; and the use of play to facilitate therapeutic interventions.

E.13.a.
E.13.b.

It is recommended that, with the consent of the family, the program provide information and education to the peers and siblings of the person served on activity limitations and participation restrictions.

E.15.f.(1)
E.15.f.(2)
E.15.n.(1)

The education and training program for the family/support system of the children and adolescents served includes the knowledge and capacity to describe and discuss ability, activity, and participation with transition to home school and the community. It is recommended that the education and training also include information on sexuality, both normal development and after injury, illness, or impairment and passenger safety including laws.

Consultation

- It is suggested that WTRC consider expanding its visiting hours to provide more opportunities for the family and peers to visit and be involved in the child or adolescent patient's program.

SECTION 3. PROGRAM STANDARDS

A. Comprehensive Integrated Inpatient Rehabilitation Program

Inpatient Rehabilitation Program - Hospital (Adults)

Inpatient Rehabilitation Program - Hospital (Children and Adolescents)

Key Areas Addressed

- Preadmission assessment
- Privileging process
- Appropriate placement in the continuum of services
- Secondary prevention
- Rehabilitation nursing services
- Rehabilitation physician/medical services and management
- Program-specific information-gathering requirements
- Information gathering regarding durability of outcomes
- Provision of services to any persons with spinal cord dysfunction or persons with limb loss

Note: *Recommendations, consultation, and exemplary conformance in this section of the report do not include those specific to specialty programs included in the survey. If specialty program accreditation was sought, the relevant specialty program section of the report includes recommendations, consultation, and areas of exemplary conformance for all portions of Section 3 of the standards manual that were applied to the specialty program.*

Recommendations

A.19.

It is recommended that all personnel who care for patients with limb loss demonstrate competencies in amputation management.

A.29.

It is recommended that all personnel who care for patients with spinal cord dysfunction demonstrate competencies in spinal cord dysfunction management.

Consultation

- It is suggested that the rehabilitation unit individualize its recommendation for the intensity of services on the preadmission-screening form to enhance the patients' experience with the program.

J. Stroke Specialty Program

Inpatient Rehabilitation Program - Hospital: Stroke Specialty Program (Adults)

- Standards in Section 3.A. Comprehensive Integrated Inpatient Rehabilitation Program have been applied to this program.

Key Areas Addressed

- Intervention services provided for persons served and their families/support systems
- Prevention of recurrent stroke and the complications of stroke
- Reducing activity limitations and decreasing environmental barriers
- Continuum of services
- Provision of services to any persons who require ventilatory assistance
- Health assessments and promotion of wellness
- Education for persons served and their families/support systems
- Maximizing participation and quality of life
- Discharge/transition recommendations
- Data collection regarding the effectiveness of the program

Note: *Recommendations, consultation, and exemplary conformance in this section of the report include all portions of Section 3 of the standards manual that were applied to the specialty program.*

Recommendations

There are no recommendations in this area.

Consultation

- It is suggested that the stroke specialty program individualize its recommendation for the intensity of services on the preadmission-screening form to enhance the patients' experience with the program.

QUALITY IMPROVEMENT PLAN

MED

Company ID Number: 20680

West Tennessee Rehabilitation Center
620 Skyline Drive
4th Floor
Jackson, TN 38301
US

Survey Number: 69817
Accreditation Decision: Three-Year Accreditation
Accreditation Expiration Date: 12/31/2016
Survey Date(s): 11/21/2013 through 11/22/2013

Return to CARF by 4/23/2014

Completed by (Name): Julie Taylor

Date Completed: 4/1/2014

Job Title: Program Director

Standard Number for Recommendation	Action to be Taken	Completion Date (Actual or Estimated)
A.5.a. (2)	Will add to our cultural and diversity plan that will include our personnel.	6/2014
A.6.b.(2)(a) A.6.b.(2)(b)	Include time frames in policy and procedures that address violations of ethical codes so that they are addressed timely.	7/2014
C.2.c. (2)	Prioritize goals and objectives in the strategic business plan.	Completed 1/2014
F.7.a-F.7.b.(3)	Complete billing audits quarterly for each fiscal year. (Data was available for 2012/2013—no data for 2011)	Completed 2012 &ongoing
H.6.a.(1) H.6.b.-H.6.d.	Complete emergency drills on each shift annually and provide written analysis in the areas that need improvement. (Data available for 2012/2013—no data 2011)	Completed 2012 & ongoing
H.9.a-H.9.b. (8)	Record all critical incidents on the unit and summarize annually in written form all trends, action plans, and results. (Data for 2012/2013—no data 2011)	Completed 2012 & ongoing
1.2.b.(2)	The policy and procedure will be reviewed to meet the standard of completing background checks throughout employment.	6/2014
1.6.b.(4)(a)	Update performance evaluations so that the employee goals are addressed specifically (achieved, modified, or not completed).	7/2014
K.5.a-K.5.b.(3)	Record all formal complaints and complete an annual, written analysis and include causes, action plan, and results. (Data for 2012/2013—no data 2011)	Completed 2012 & ongoing

Standard Number for Recommendation	Action to be Taken	Completion Date (Actual or Estimated)
L.3.c.(1) L.3.c.(2)	Include progress in removing barriers to accessibility in the Accessibility Plan.	7/2014
M.6.b.(4)(b)	Collect data from other stakeholders to include referral sources, physicians, and staff.	7/2014
M.7.a-M.7.d	Collect data from stakeholders and select specific performance indicators and measure against the industry benchmarks. Identify to whom the indicator will be applied, who is responsible for data collection, the source from which the data will be collected.	7/2014
N.1.a N.1.b (2)(d)ii- N.1.c.(3)	Complete an annual written analysis of performance indicators from other stakeholders and include action to be taken, outcomes, and results.	Completed 1/2014 & ongoing
2.A.11.c-A.11.e	Complete staff satisfaction survey to address educational programs and opportunities.	7/2014
2.A.14.a-A.14.c 2.A.14.e.(1)- 2.A.14.e.(2)	Review denials and referrals that do not qualify for admission and address causes, trends, actions for improvement, results. (Data for 2012/2013—no data 2011)	Completed 2012 & ongoing
2.B.8.6	Change the written disclosure statement so that the intensity of services is individualized to meet the patients needs.	7/2014
2.B.38.a.(1) 2.B.38.a.(8)	Include in the written disclosure statement characteristics of persons served and include transfers to acute by diagnostic category.	7/2014
2.B.45.z	Include the location of audiovisuals in the patient record.	7/2014
2.E.6.d.(1) 2.E.6.d.(2) 2.E.6.g 2.E.6.h	Rehab staff will complete competencies for adolescents and address sexuality, normal development and development after injury, setting boundaries, and use of therapeutic play.	7/2014
2.E.13.a 2.E.13.b	Provide adolescents with the opportunity to share information with peers and siblings regarding their mobility limitations.	7/2014
2.E.15.f.(1) 2.E.15.f.(2) 2.E.15.n.(1)	Provide education and training for family/support systems of adolescents and include in the education sexuality, normal development and development after injury and passenger safety laws.	7/2014
2.A.19	Rehab staff will complete competencies that address limb loss and management of amputations.	7/2014

Standard Number for Recommendation	Action to be Taken	Completion Date (Actual or Estimated)
2.A.29	Rehab staff will complete competencies that address spinal cord dysfunction and management of SCI injuries.	7/2014

CARF INTERNATIONAL
6951 East Southpoint Road
Tucson, AZ 85756 USA
Toll-free 888 281 6531
Tel/TTY 520 325 1044
Fax 520 318 1129

CARF-CCAC
1730 Rhode Island Avenue, NW, Suite 410
Washington, DC 20036 USA
Toll-free 866 888 1122
Tel 202 587 5001
Fax 202 587 5009

CARF CANADA
10665 Jasper Avenue, Suite 760
Edmonton, AB T5J 3S9 CANADA
Toll-free 877 434 5444
Tel 780 429 2538
Fax 780 426 7274

Supplemental #2
-ORIGINAL-

WEST TENNESSEE REHABILITATION CENTER

CN1510-044

West Tennessee Healthcare

620 Skyline Drive • Jackson, Tennessee 38301 • 731-541-5000 • www.wth.org

November 11, 2015

Mr. Jeff Grimm
HSD Examiner
Tennessee Health Service and Development Agency
502 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

RE: Certificate of Need Application CN1510-044
West Tennessee Rehabilitation Center – Establishment of a 48 Bed Freestanding Rehabilitation Hospital-Responses

Dear Mr. Grimm:

We are in receipt of your questions for items that need clarification or additional information. Below please find our responses.

2. Section A, Applicant Profile, Item 6

Please also provide a fully executed/signed and dated option to lease or similar document between West Tennessee HealthCare, Inc. and the applicant LLC confirming the applicant's legal interest in the site. The document should identify the term and estimated lease cost of the agreement and must be valid on the date of the hearing of the application.

The signed but undated ground lease provided in Exhibit 2 of the supplemental response is noted. Please address the following:

- **A date must be included in the Intent to Lease Agreement in order to confirm legal interest in the state that is valid on the date of the hearing of the application by the HSDA Agency Board (e.g. January 27, 2016). Please clarify.**
- **The 20 year term of the lease does not match the 35 year term identified in the comments provided on page 29 of the application (description of methodology). As such, the documentation does not support the $8,138,158 cost in Item B.3 of the Projected Data Chart. Please clarify.**

SUPPLEMENTAL #2
November 12, 2015
11:52 am

- **No cost was provided in the copy of the Intent to Lease Agreement in Exhibit 2. As such, the documentation does not support the $8,138,158 cost provided in Item B.3 of the Projected Data Chart. Please clarify.** ***Note:*** *Article 2 of the Intent to Lease Agreement states that rent shall be established between Landlord and Tenant based on the appraised fair market value rent for the Demised Premises, as may be adjusted during the term. This cost differs from the description of the ground lease cost on page 29 of the application ($28,000 per acre for 5.58 acres over 35 years with a 2 percent increase each year).*

Response: Attached as Exhibit 1 is a signed Intent to Lease Agreement dated November 4, 2015. Article 2, Term of Lease and Rental of the Intent to Lease Agreement details that the Ground Lease will be for an initial period of 20 years. The initial annual amount of the lease is $90,200 with annual increases of 1.5 percent. The total amount of the lease over the 20 years is $2,085,755, which is greater than the current fair market value of the land (see below). The total amount of lease payments over 20 years ($2,085,755) is the cost of the land in the revised Project Costs Chart in Exhibit 2.

As a result of the differences noted, it appears that the Intent to Lease Agreement provided in Exhibit 2 of the supplemental response does not (a) confirm the applicant's legal interest in the site and (b) support the $8,138, 158 costs shown in Item B.3 of the Projected Data Chart. Please provide a fully executed (dated and signed) amended Intent to Lease Agreement.

Response:

Exhibit 2 contains a replacement page 30-R, Project Costs Chart.

Exhibit 3 contains replacement pages 35-R and 36-R, Projected Data Chart to reflect the revised amounts for rent in years one and two.

Given the concerns with the cost of the ground lease, please note that the $8,138,158 ground lease cost in the Projected Data Chart must be higher than the current estimated fair market value (FMV) of the 5.58 acre site, for CON purposes in accordance with Agency statue. Please provide documentation of the property's FMV in the form of a current tax record from the Madison County assessor's Office or a letter attesting to the appraised value of the property by a licensed appraiser, qualified real estate broker, or the equivalent. If the FMV is higher, please identify the cost and submit a revised Project Cost Chart labeled as replacement page 30-R.

SUPPLEMENTAL #2
November 12, 2015
11:52 am

Response: David Horton & Associates has completed an appraisal of the 5.59 +/- acres located at 616 West Forest Avenue in Jackson, TN. The appraisal has an effective date of October 26, 2015 with the purpose being to provide an opinion of annual market rent. The appraisal of the 5.59 acres shows a market value of the subject as vacant to be $215,000 per acre for a total of $1,202,000. A copy of the full appraisal is contained in Exhibit 4.

6. **Section B, Project Description, Item II.D.**

   The benefits of the proposed freestanding rehab facility facilitated, in part, by the de-licensure of the hospital's 48-bed rehab unit are noted. With respect to the existing hospital unit, please provide examples of plans for the use of the vacated 48-bed unit.

   The potential use of the vacated space containing the 48 beds that the hospital will de-license is noted. In terms of future development projects that may involve recapturing all or some of the 48 beds on the vacated unit, it appears that the applicant will need to prepare and submit a Certificate of Need application for the addition of beds at some future date. Please briefly explain the pros and cons of de-licensing the 48 beds at the hospital at this time.

Response: The initial response regarding "recapture" of lost beds referred to beds that will be lost when existing rooms in other parts of the hospital are renovated to make them bigger, not to "recapture" any of the 48 rehabilitation beds.. A certificate of need will not be necessary to use the vacated West Tennessee Rehabilitation Unit unless the cost of renovation exceeds $5 million, because the number of licensed beds will not increase. A certificate of need would be required to convert the rehabilitation beds to acute care beds, and Jackson-Madison General County Hospital does not believe its current and projected acute care inpatient census justifies the addition of acute inpatient beds.

12. **Section C. Need Item 5**

    The response identifying certified inpatient rehab beds in the primary and secondary service area is noted. Please complete the table below showing utilization of HealthSouth Cane Creek Hospital to complement the utilization provided for West Tennessee Rehabilitation Center in Section C, Need, Item 6.

The table provided in the response is noted. What are the primary factors that account for the decline in licensed bed occupancy of the HealthSouth Cane Creek hospital from 2012-2014? Given the regional proximity, would any of these also have a potential impact on the occupancy of the proposed freestanding rehab hospital?

Response: From the period from 2010 to 2014, the number of average annual discharges from Cane Creek was 758 discharges with a standard deviation of 37.7. The 735 discharges for 2014 lies within 1 standard deviation of the 5-year average and may be attributed to random fluctuation. Over the same period, the average number of patient days was 9,997 days with a standard deviation of 515 days. The 9,482 days for 2014 is slightly more than 1 standard deviation away from the 5-year average. However, the 2014 ALOS of 12.8 days was lower than the 5-year average of 13.2 days. At 13.2 days, the 735 discharges for 2014 would have been much closer to the 5-year average at 9,702 days. We do not believe that this will have any bearing on the occupancy at the proposed project location. Another factor to consider is that the host county for the proposed project, Madison County, has a much larger population than Weakley County, the host county for the Cane Creek hospital.

13. Section C. Need Item 6

Of the thirteen specific diagnoses defined by CMS as part of the "60 Percent Rule", including Stroke; Spinal Cord Injury; Amputation; Major Multiple Trauma; Fracture of the Femur (hip fracture); Brain Injury; Neurological Disorders; Burns; Active Polyarticular Rheumatoid Arthritis; Congenital Deformities; Systemic Vasculidities; Severe or Advanced Osteoarthritis; Hip and Knee Replacements accompanied by extreme obesity with a body mass index of at least 50, or be 85 years of age or older, which ones will apply to the proposed freestanding rehabilitation hospital? Please provide the projection numbers for each of the anticipated diagnoses and the methodology used to reach the projection numbers.

SUPPLEMENTAL #2
November 12, 2015
11:52 am

The table provided in the response refers to cases in lieu of projected patient discharges for 2018 as referenced in the remarks preceding the table. Please revise the name of the column heading. Please also add a row to show the totals in the table.

	HealthSouth Average Q2—2015	2018 Estimated Discharges
Neurological	21.1%	235
Stroke	17.1%	191
Debility	9.7%	108
Other Orthopedic	9.1%	101
Brain Injury	8.9%	99
Fracture Lower Extremity	8.8%	98
Knee/Hip Replacement	6.2%	69
Major Multiple Trauma	4.5%	51
Cardiac	4.3%	48
All Other	10.3%	115
Total		1,115

15. **Section C, Economic Feasibility, Item 4 (Historical and Projected Data Charts)** *Historical Data Chart – Please provide a Historical Data Chart for Jackson-Madison County General Hospital.*

The Historical Data Chart for the hospital is noted. In comparing to the audited financial statements of West Tennessee Healthcare that were submitted with the original application, please briefly explain why bad debt and net patient service revenues in the financial statements are higher than those in the chart. If for related entities other than the hospital, please identify.

Response: The audited financial statements of West Tennessee Healthcare include the following related entities: Jackson-Madison County General Hospital, Bolivar General Hospital, Camden General Hospital, Milan General Hospital, Pathways Behavioral Health, Medical Center Medical Products, West Tennessee Medical Group, Health Partners, and Therapy & Learning Center. Prior to FY2015, the financial statements also included the related entities of Humboldt General Hospital and Gibson General Hospital.

SUPPLEMENTAL #2
November 12, 2015
11:52 am

18. Section C, Economic Feasibility, Item 9

The Medicare and TennCare/Medicaid payor mix is noted. Please also complete the table below.

Applicant's Projected Payor Source, Year 1

Payor Source	*Gross Revenue*	*as a % of Total*	*Average Gross Charge/Patient Day*
Medicare	*19,150,375*	*75.0%*	*$1,813.74*
Tenncare	*567,847*	*2.2%*	*$1,813.74*
Managed Care	*	*	
Commercial	*4,244,325*	*16.6%*	*$1,813.74*
Self-Pay	*1,574,907*	*6.2%*	*$1,814.41*
Other	**	**	
Total Gross Revenue	*25,537,454*	*100.0%*	

*Managed Care figure combined with Commercial.
**Other figure combined with Self-Pay.

The $29,619,405 amount provided for gross operating revenue in the payor mix table differs from the $25,537,454 amount shown in the Projected Data Chart provided in Exhibit 10. Please clarify. If in error, please revise the payor mix table provided above.

20. Section C, Contribution to Orderly Development, Item 3

The staffing plan for the proposed facility is noted. It appears there is 1 FTE each for RN, LPN and Nurse Aide staff for a total of 3.0 FTE nursing staff budgeted for 24/7 direct nursing care of patients admitted to the proposed hospital. Based on 14,080 patient days, the direct care staffing calculates to approximately 2.26 direct nursing hours per patient per day in Year 1 of the project (14,080 patient days/6,240 direct nursing hours). This staffing plan appears to be lower than might be expected for an inpatient rehabilitation facility. Please clarify.

The response appears to indicate that there should be approximately 54.5 FTEs staffed by nursing positions in Year 1 of the project. As such, please revise the staffing plan submitted on pages 42 and 43 of the application and submit as replacement pages labeled 42-R and 43-R. In your response, please also provide an FTE total for all the positions shown in the plan.

Response: Exhibit 5 contains replacement pages 42-R, 43-R, and 44-R.

Should you have any questions or require additional information, please do not hesitate to contact me at vicki.lake@wth.org or (731) 984-2160.

Sincerely,

Victoria S. Lake
Director, Market Research and Community Development

cc: Walter Smith, HealthSouth Corporation
Dan Elrod, Butler Snow
Currie Higgs, West Tennessee Healthcare
Jeff Blankenship, West Tennessee Healthcare

SUPPLEMENTAL #2
November 12, 2015
11:52 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Madison

NAME OF FACILITY: West Tennessee Rehabilitation Center

I, VICTORIA S. LAKE, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Victoria S. Lake
Signature/Title
Director, Market Research + Community Development

Sworn to and subscribed before me, a Notary Public, this the 30 day of October, 2015, witness my hand at office in the County of Madison, State of Tennessee.

NOTARY PUBLIC

My commission expires 9-21, 2016.

HF-0043

Revised 7/02

RANDALL L HAMPTON
STATE OF TENNESSEE NOTARY PUBLIC
MADISON COUNTY TN

SUPPLEMENTAL #2

November 12, 2015
11:52 am

Exhibit 1

SUPPLEMENTAL #2
November 12, 2015
11:52 am

70297102615-WCB

STATE OF TENNESSEE :
COUNTY OF MADISON :

INTENT TO LEASE AGREEMENT

This **INTENT TO LEASE AGREEMENT** (this "**Agreement**") is made and entered into effective as of the 4th day of November, 2015, by and between **WEST TENNESSEE HEALTHCARE, INC.**, a Tennessee nonprofit corporation and governmental instrumentality of Jackson-Madison County General Hospital District ("**Landlord**"), and **WEST TENNESSEE REHABILITATION HOSPITAL, LLC**, a Delaware limited liability company ("**Tenant**").

WITNESSETH:

WHEREAS, Landlord owns that certain tract or parcel of land located at 616 West Forest Avenue in Jackson, Tennessee, which land is more particularly described on Exhibit A attached hereto and incorporated herein by this reference (the "**Land**"), and intends to enter into a Ground Lease ("**Ground Lease**") with Tenant; and

WHEREAS, Tenant is a joint venture between Jackson-Madison County General Hospital District and HealthSouth West Tennessee Holdings, LLC, and the Tenant will provide rehabilitation services to people of the Jackson-Madison County area; and

WHEREAS, Tenant intends to construct certain improvements on the Land (a "**Building**") and necessary parking and other infrastructure improvements ("**Other Improvements**") (the Other Improvements together with the Building, collectively the "**Improvements**"), pursuant to the terms of a Consulting Services Development Agreement; and

WHEREAS, the public will benefit from the enhanced delivery of patient care services in the form of a new rehabilitation facility.

NOW, THEREFORE, In consideration of the rent to be paid, the mutual covenants and agreements herein contained, and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

ARTICLE 1.
PREMISES

Landlord intends to demise and rent the Land unto Tenant, and Tenant intends to rent and hire from Landlord the Land, herein called the Leased Premises, together with any and all improvements located thereon and appurtenances thereto (collectively, the "**Demised Premises**"); together with the non-exclusive right of ingress and egress for pedestrian and vehicular traffic to and from the Building over all sidewalks and walkways and roadways as reflected as Ingress and Egress areas on a recorded plat in the Register's Office of Madison County, Tennessee, on Landlord's property adjacent to the Demised Premises.

The foregoing rights and easements shall be appurtenant to the Demised Premises and are hereinafter included in the definition of the Demised Premises.

ARTICLE 2.
TERM OF LEASE AND RENTAL

Unless the Ground Lease is terminated pursuant to the provisions to be agreed upon, the initial term of the Ground Lease shall be for a period of twenty (20) years (the "**Initial Term**"), commencing on the commencement date set forth in the Ground Lease (the "**Commencement Date**"), and ending on the last day of the month during which the twentieth (20^{th}) anniversary of the Commencement Date occurs (the "**Expiration Date**"). On or about the Commencement Date, Landlord and Tenant shall execute a written agreement establishing the Commencement Date.

At the end of the Initial Term, Tenant shall have the right to extend the term for five (5) consecutive renewal terms of five (5) years each (each, a "**Renewal Term**"). The Initial Term, together with all exercised Renewal Terms, shall hereinafter be referred to as the "**Term**".

Rent shall be as established between Landlord and Tenant at an initial annual amount of $90,200 per annum, based on the appraised fair market value rent for the Demised Premises, and will be subject to annual increases at the rate of one and one-half percent (1.5%) during the Term.

ARTICLE 3.
LANDLORD IMPROVEMENTS

Prior to the Commencement Date, Landlord, at its sole cost and expense, intends to raze the building structures on the Land and remove the debris therefrom, and leave the Land in such condition as exists after the debris removal (i.e. not pad ready). Further, Landlord intends to make available, or cause to be made available to the Demised Premises, all utilities and similar services (together "**Utilities**"), including without limitation water, sewer, gas, electricity, telephone and telecommunications. The razing of the existing structures on the Land and providing the availability of utilities shall be referred to as the "**Landlord Improvements**." Such Utilities are planned to be made available to the Demised Premises at or prior to the Commencement Date, or at such other time as such shall be acceptable to Tenant and shall be made available in such quantities or having such capabilities and capacities as are consistent with the intended use of the Demised Premises. No other Landlord Improvements to the Demised Premises are required as a condition of the Ground Lease. All other improvements are the responsibility of Tenant.

ARTICLE 4.
TENANT IMPROVEMENTS AND ALTERATIONS

Tenant intends to develop, construct and operate upon the Demised Premises, at its sole cost and expense, the Building and Other Improvements.

ARTICLE 5.
TITLE AND OWNERSHIP

Landlord is the fee simple owner of the Land. Landlord represents and warrants that Landlord is authorized to execute this Agreement for a Ground Lease for the Term herein granted under the terms and conditions provided herein and that the Ground Lease will be enforceable against Landlord in accordance with its terms. Landlord agrees to provide an opinion of counsel acceptable to Tenant that proper action has been taken by its Board of Trustees to enter into the Ground Lease.

ARTICLE 6.
USE OF PREMISES; QUIET ENJOYMENT

(a) Use Of Premises. The Tenant agrees that the Demised Premises will be used solely and exclusively as a rehabilitation hospital unless otherwise consented to in writing in advance by Landlord, in its reasonable discretion. Further, Tenant agrees that the Demised Premises shall be used and occupied in a lawful manner.

(b) Tenant's Quiet Enjoyment. Landlord covenants that Tenant, on the performance of the terms and conditions of the Ground Lease, will and may peaceably and quietly have, hold and enjoy the Demised Premises for the full term of the Ground Lease, subject to any condemnation provision in the Ground Lease.

ARTICLE 7.
TERMINATION OF LEASE; TITLE TO IMPROVEMENTS

Upon termination of the Ground Lease, either by default of Tenant or expiration of the Term (subject to the terms of the Ground Lease), the Improvements on the Demised Premises will be and become the property of the Landlord.

ARTICLE 8.
SUCCESSORS AND ASSIGNS

The covenants, conditions and agreements contained in the Ground Lease are intended to bind and inure to the benefit of Landlord and Tenant and their respective successors and permitted assigns; provided, however, that, subject to the terms of the Ground Lease, Tenant shall not assign or otherwise transfer its Leasehold Interest without the prior written consent of Landlord, which consent shall not be unreasonably withheld, conditioned nor delayed. Upon a transfer by Landlord or Tenant of its respective estate or interest in the Demised Premises or the Improvements, the transferring party (the "**Transferring Party**") shall notify the other party in writing of such transfer. The Transferring Party will be relieved from any breach of covenants or obligations under the Ground Lease arising or occurring after the date of transfer of the Transferring Party's estate or interest in the Demised Premises or the Improvements.

ARTICLE 9.
DISPUTES

Disputes shall be resolved as agreed between Landlord and Tenant.

ARTICLE 10.
NET LEASE

The Rent payable under the Ground Lease shall be absolutely net to Landlord so as to yield to Landlord in each year during the Term, the Rent so specified, free of any charges, assessments, impositions or deductions of any kind charged, assessed, or imposed on or against the Demised Premises. Except as otherwise specifically provided for by any provision of the Ground Lease, all costs, expenses and obligations of any kind which may arise or become due during the Term relating to the maintenance and operation of the Demised Premises, including all alterations, repairs, reconstruction and replacements as provided in the Ground Lease, shall be paid by Tenant, and Landlord shall be indemnified and saved harmless by Tenant from and against such costs, expenses and obligations.

ARTICLE 11.
GROUND LEASE

Landlord and Tenant acknowledge and agree that a Ground Lease shall be executed upon the granting of a Certificate of Need by the State of Tennessee and completion of information needed to finalize a Ground Lease.

ARTICLE 12.
LEASE CONDITIONED UPON GOVERNMENT APPROVALS

Notwithstanding anything contained in this Agreement or elsewhere to the contrary, Tenant's obligations and Landlord's obligations under the Ground Lease shall be conditioned upon Tenant's attainment of all governmental, quasi-governmental and other approvals (including the issuance of a Certificate of Need by the State of Tennessee) and permits necessary for construction of the Building and its use thereof as a rehabilitation hospital building (collectively, the "**Approvals**") on or before June 30, 2016 (the "**Approvals Deadline**"). Tenant agrees to act diligently, at its expense, in the process of obtaining the Approvals, and Landlord agrees to assist as needed and as requested, in obtaining the Approvals.

Denial of one or more Approvals or the failure of Tenant to obtain all Approvals by the Approvals Deadline shall entitle Tenant or Landlord on each occasion to terminate this Agreement upon written notice to the other party, given within thirty (30) days after a denial or the Approvals Deadline, as applicable. Upon such termination, neither Landlord nor Tenant shall have any further obligations hereunder.

Notwithstanding the foregoing, Tenant shall have the right, in its sole discretion, to extend the Approvals Deadline one (1) or more times, not to exceed a total of one hundred eighty (180)

days, by providing written notice to Landlord of each such extension at least ten (10) days prior to the then-current Approvals Deadline.

[Signature Page Follows]

IN WITNESS WHEREOF, the parties hereto have executed this Intent to Lease as of the day and year first above written.

LANDLORD:

WEST TENNESSEE HEALTHCARE, INC.,
a Tennessee nonprofit corporation and governmental instrumentality of Jackson-Madison County General Hospital District

By: Bobby Addy
Title: CEO

TENANT:

WEST TENNESSEE REHABILITATION HOSPITAL, LLC, a Delaware Limited Liability Company

By: HealthSouth West Tennessee Holdings, LLC
Its: Member

By: Arthur E Wilson Jr
Title: BY: ARTHUR E. WILSON
ITS: AUTHORIZED REPRESENTATIVE

By: Jackson-Madison County General Hospital District
Its: Member

By: Bobby Addy
Title: CEO

SUPPLEMENTAL #2
November 12, 2015
11:52 am

EXHIBIT A

[Legal Description of the Land]
PROPERTY DESCRIPTION
5.59 Acres - West Tennessee Healthcare, Inc. Property
City of Jackson, Madison County, Tennessee

A parcel of land located in the City of Jackson, Madison County, Tennessee, being a part of that property conveyed unto West Tennessee Healthcare, Inc. by Warranty Deed of record in Deed Book 696, Page 1583 in the Register's Office of said county, and being more particularly described as follows:

Begin at the intersection of the south right-of-way line of West Forest Avenue (60 foot right-of-way) with the east right-of-way line of Linda Vista Drive (50 foot right-of-way), said point being monumented by a set ½-inch iron rod with aluminum identification cap stamped "PLS INC JACKSON TN" (typical of all iron rods referred to herein as set); thence, with the south right-of-way line of West Forest Avenue, South 87 degrees 00 minutes 59 seconds East, 608.90 feet, to an iron rod set; thence, with the arc of a curve turning to the right, having a radius of 17.50 feet, an arc length of 28.48 feet, and a chord bearing and length of South 40 degrees 23 minutes 11 seconds East, 25.44 feet, to an iron rod set on the west right-of-way line of Forest Cove (50 foot right-of-way); thence, with said west right-of-way line, South 06 degrees 14 minutes 37 seconds West, 423.61 feet, to a ½-inch iron rod found at the northeast corner of Forest Cove Long Term Facility, Inc. (Deed Book 708, Page 815); thence, with the north line of Forest Cove Long Term Facility, North 87 degrees 02 minutes 23 seconds West, passing through an iron rod set on the east side of a drainage ditch at a distance of 362.66 feet, but continuing for an overall distance of 414.12 feet, to a point on the east line of Chelsea and Zachary Livelli (Deed Book 722, Page 1858); thence, with the east line of Livelli, North 07 degrees 06 minutes 13 seconds East, 63.35 feet, to an iron rod set at the southeast corner of Shirley Faye Adams (Deed Book 566, Page 729); thence, with the east line of Adams, North 07 degrees 49 minutes 53 seconds East, 78.53 feet, to a scribe mark set on the top west side of a retaining wall and at the northeast corner of Adams; thence, with the north line of Adams, North 87 degrees 00 minutes 49 seconds West, 200.00 feet, to a magnetic survey nail set in an asphalt drive and on the east right-of-way line of said Linda Vista Drive; thence, with said east right-of-way line, along the arc of a curve turning to the left, having a radius of 131.50 feet, an arc length of 28.60 feet, and a chord bearing and length of North 08 degrees 44 minutes 49 seconds East, 28.54 feet, to a point; thence, continuing with said east right-of-way line, North 02 degrees 30 minutes 59 seconds East, 271.76 feet, to the point of beginning and containing 5.59 acres of land.

Attest:

A. Brent Dean
Tennessee R.L.S. 2205
October 27, 2015

SUPPLEMENTAL #2
November 12, 2015
11:52 am

Exhibit 2

SUPPLEMENTAL #2
November 12, ~~2015~~ 2016
11:52 am

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$ 1,908,000
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$ 100,000
	3.	Acquisition of Site	
	4.	Preparation of Site	$ 3,045,315
	5.	Construction Costs	$12,730,623
	6.	Contingency Fund	$ 1,273,062
	7.	Fixed Equipment (Not included in Construction Contract)	$ 2,304,022
	8.	Moveable Equipment (List all equipment over $50,000)	$ 3,850,000
	9.	Other (Specify) ACE-IT Med Records	$ 935,000
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	
	2.	Building only	
	3.	Land only	$ 2,085,755
	4.	Equipment (Specify) _____	
	5.	Other (Specify) _____	
C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)		$28,231,777
E.	CON Filing Fee		$ 45,000
F.	Total Estimated Project Cost (D+E)		
		TOTAL	$28,276,777

SUPPLEMENTAL #2
November 12, 2015
11:52 am

Exhibit 3

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year2018	Year2019
A.	Utilization Data (discharge days)	14,080	14,846
B.	Revenue from Services to Patients		
1.	Inpatient Services	$25,410,402	$28,239,259
2.	Outpatient Services	127,052	141,196
3.	Emergency Services		
4.	Other Operating Revenue (Specify) _____		
	Gross Operating Revenue	**$25,537,454**	**$28,380,455**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 7,952,694	$ 8,838,041
2.	Provision for Charity Care	686,843	763,307
3.	Provisions for Bad Debt	197,752	219,767
	Total Deductions	**$ 8,837,289**	**$ 9,821,115**
NET OPERATING REVENUE		**$16,700,165**	**$18,559,340**
D.	Operating Expenses		
1.	Salaries and Wages	$8,809,612	$9,051,638
2.	Physician's Salaries and Wages	148,722	151,697
3.	Supplies	893,142	960,595
4.	Taxes	777,474	897,788
5.	Depreciation	1,494,397	1,814,943
6.	Rent	90,200	91,553
7.	Interest, other than Capital		
8.	Management Fees		
	a. Fees to Affiliates	1,362,667	920,907
	b. Fees to Non-Affiliates		
9.	Other Expenses – Specify on Page 23	2,625,731	2,782,548
	Total Operating Expenses	**$16,201,945**	**$16,671,669**
E.	Other Revenue (Expenses) – Net (Specify) _____	$	$
NET OPERATING INCOME (LOSS)		**$ 498,220**	**$ 1,887,671**
F.	Capital Expenditures		
1.	Retirement of Principal	$	$
2.	Interest		
	Total Capital Expenditures	**$**	**$**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		**$ 498,220**	**$ 1,887,671**

PROJECTED DATA CHART – OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2018	Year 2019
1. Equipment Rental & Maintenance	$ 398,447	$ 428,539
2. Utilities/Telephone (annual)	345,557	352,468
3. Contract Services	756,433	813,562
4. Other Variable Expenses	490,286	527,315
5. CIS Expense	72,000	73,440
6. Insurance/Bonding	233,331	250,953
7. Other Fixed	329,677	336,271
Total Other Expenses	**$2,625,731**	**$2,782,548**

SUPPLEMENTAL #2
November 12, 2015
11:52 am

Exhibit 4

SUPPLEMENTAL #2
November 12, 2015
11:52 am

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

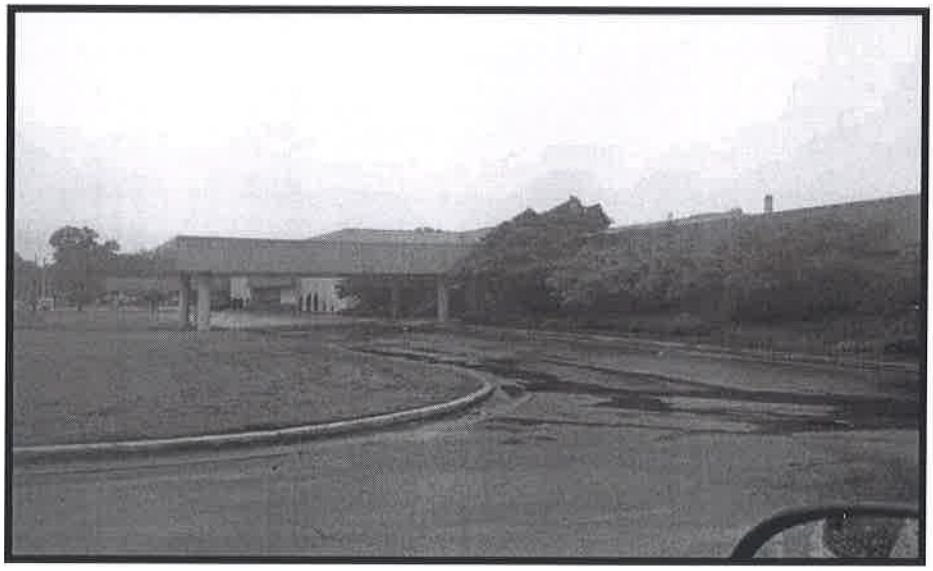
Real Estate Appraisal

On

5.59 +/- Acre Parcel (As Vacant)
616 West Forest Avenue – Jackson, TN 38301

For

West Tennessee Healthcare, Inc.
620 Skyline Drive – Jackson, TN 38301



Inspection Date:
October 26, 2015

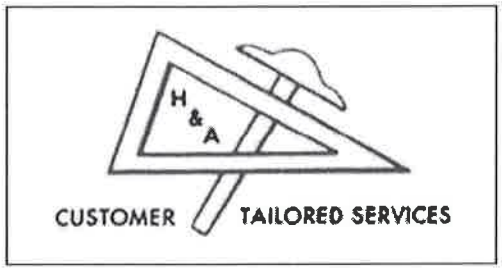
Effective Date:
October 26, 2015

Date of Report:
October 30, 2015

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

PART I. INTRODUCTION

SUPPLEMENTAL #2
November 12, 2015
11:52 am



DAVID HORTON & ASSOCIATES, INC
P O BOX 907
JACKSON, TENNESSEE 38302-0907

OFFICE: 731-422-5190
Email: dwhorton@aeneas.net

October 30, 2015

Mr. Lester Sands
West Tennessee Healthcare, Inc.
620 Skyline Drive
Jackson, TN 38301

Re: 5.59 +/- Acre Parcel (As Vacant)
616 West Forest Avenue
Jackson, TN 38301

Dear Mr. Sands,

Pursuant to your request, we have prepared an appraisal of the property located at 756 West Forest Avenue in Jackson, TN. The accompanying report is based on a site inspection of the subject, its neighborhood area of influence, and applicable market data. This appraisal has been completed in accordance with the Uniform Standards of Professional Appraisal Practice and qualifies as an Appraisal Report.

Per your request we have not given any consideration to comparable properties or transactions between healthcare entities when one of the entities is in a position to refer to the other. The Appraisal has been made with particular attention paid to applicable value-influencing economic conditions and has been processed in accordance with nationally recognized Appraisal guidelines. The purpose of the appraisal is to estimate the annual market rent of the subject property under the hypothetical condition that it was a vacant pad ready parcel. The intended user of this report is West Tennessee Healthcare Inc. The value conclusions stated herein are as of the effective date of October 26, 2015, as stated in the body of the Appraisal and subject to the Certification and Limiting Conditions attached. This market rent estimated herein is of the effective date of the report and does not consider any rent escalators or what the future rent of the property should be.

Our Rendered Opinion of the Subjects Annual Market Rent:

($90,200)

Please do not hesitate to contact us if we can be of additional service to you.

Respectfully,

Brad Dean
Certified General Appraiser
TN CG #2544

SUPPLEMENTAL #2
November 12, 2015
11:52 am

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

TABLE OF CONTENTS

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

TABLE OF CONTENTS

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

PART II. SUMMARY OF DATA/VALUE

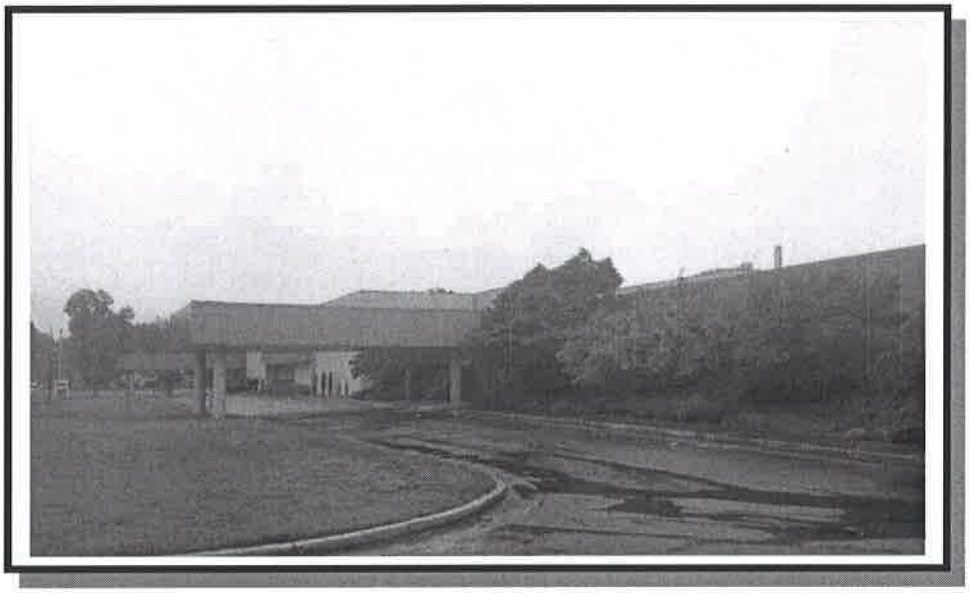
West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

SUMMARY OF SALIENT FACTS

Name:	5.59 +/- Acre Lot
Address:	616 West Forest Avenue Jackson, TN 38301
Assessor's Parcel Number:	66M – J – 1.00, 39.00
Property Owner:	West Tennessee Healthcare
Property Description	
Property Type:	Commercial
Gross Building Area (SF):	None (Hypothetical)
Number of Buildings:	None (Hypothetical)
Number of Stories:	N/A
Year Completed:	N/A
Land Area:	5.59 +/- Acres
Zoning Designation:	Medical and Related Services
Flood Hazard Data (FEMA)	
Flood Zone:	No
Community Map Number:	47113C-0164E
Effective Map Date:	August 3, 2009
Building Occupancy:	100%
Highest and Best Use	
As-If Vacant	Medical Development
As Improved	N/A
Date of Inspection:	10/26/2015
Date of Value:	10/26/2015
Date of Report:	10/30/2015
Real Property Interest Appraised:	Fee Simple
Value Indicators	Annual Market Rent
Market Value	$1,202,000.00
Annual Market Rent	$ 90,200.00
Exposure Time	1 to 2 Years

SUPPLEMENTAL #2
November 12, 2015
11:52 am

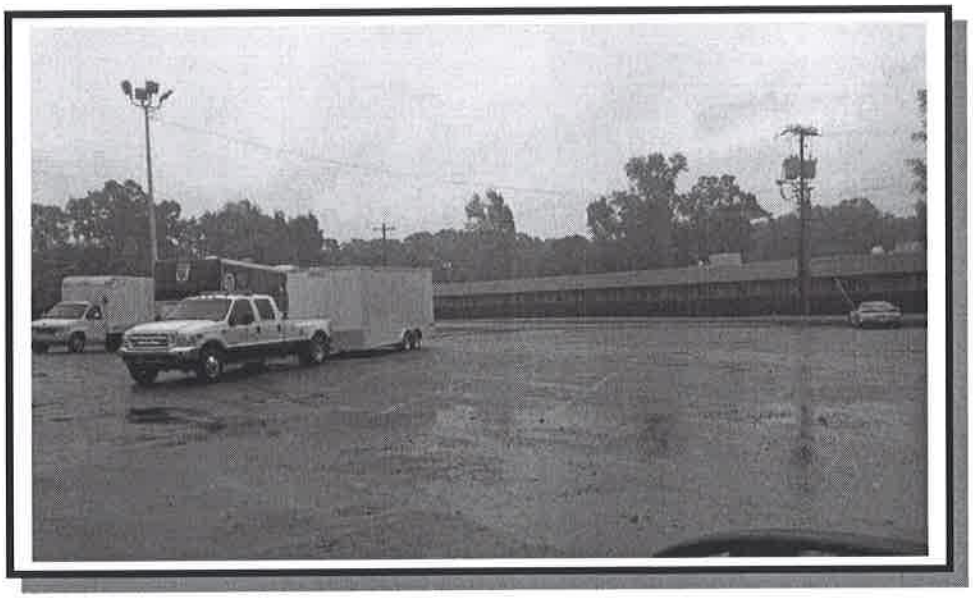
West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301



General View of Property

General View of Property

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

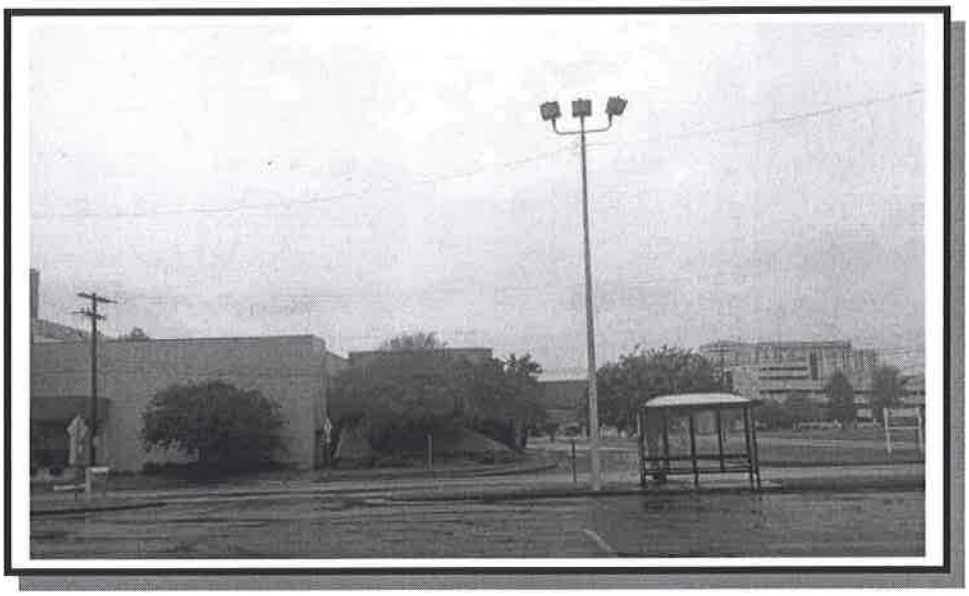


General View of Property

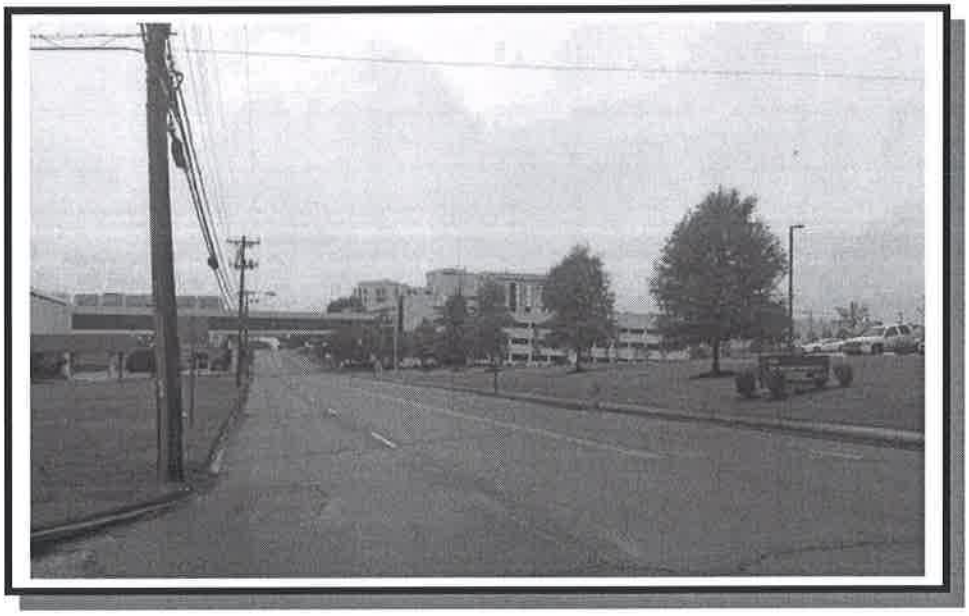
General View of Property

SUPPLEMENTAL #2
November 12, 2015
11:52 am

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301



General View of Property



Street Scene – West Forest Avenue

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

CERTIFICATE

I/we certify that, to the best of my knowledge and belief:

- the statements of fact contained in this report are true and correct.
- the reported analyses, opinions, and conclusions are limited only by the reported assumptions and limiting conditions, and are my personal, impartial, and unbiased professional analyses, opinions, and conclusions.
- I/we have no present or prospective interest in the property that is the subject of this report, and I have no personal interest or bias with respect to the parties involved.
- I/we have previously provided value opinions that included the subject property as improved but not as vacant. I/we have not provided other any services on the property that is subject of this report within the three year period immediately preceding acceptance of this assignment.
- I/we have no bias with respect to the property that is the subject of this report or to the parties involved with this assignment.
- my/our engagement in this assignment was not contingent upon developing or reporting predetermined results.
- my/our compensation for completing this assignment is not contingent upon the development or reporting of a predetermined value or direction in value that favors the cause of the client, the amount of the value opinion, the attainment of a stipulated result, or the occurrence of a subsequent event directly related to the intended use of this appraisal.
- my/our analyses, opinions and conclusions are developed, and this report has been prepared, in conformity with the Uniform Standards of Professional Appraisal Practice.
- I/we have made a personal inspection of the property that is the subject of this report.
- no one provided significant professional assistance to the person(s) signing this report, other than, those named within this report.

Brad Dean
Certified General Appraiser #2544

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

CERTIFICATION AND STATEMENT OF LIMITING CONDITIONS

CERTIFICATION: The Appraiser certified and agrees that:

1. The Appraiser has no present or contemplated future interest in the property appraised; and neither the employment to make the appraisal, nor the compensation for it, is contingent upon the appraised value of the property.

2. The Appraiser has no personal interest or bias with respect to the subject matter of the appraisal report or the participants to the sale. The "Estimate of Market Value" in the appraisal report is not based in whole or in part upon the race, color or national origin of the prospective owners or occupants of the properties in the vicinity of the property appraised.

3. The Appraiser has personally inspected the property, both inside and out, and has made an exterior inspection of all comparable sales listed in the report. To the best of the Appraiser's knowledge and belief, all statements and information in this report are true and correct, and the Appraiser has not knowingly withheld any significant information.

4. All contingent and limiting conditions are contained herein (imposed by the terms of the assignment or by the undersigned affecting the analyses, opinions, and conclusions contained in the report).

5. This appraisal report has been made in conformity with and is subject to the UNIFORM STANDARDS OF PROFESSIONAL APPRAISAL PRACTICE.

6. All conclusions and opinions concerning the real estate that are set forth in the appraisal report were prepared by the Appraiser whose signature appears on the appraisal report, unless indicated as "Review Appraiser". No change of any item in the appraisal report shall be made by anyone other than the Appraiser, and the Appraiser shall have no responsibility for any such unauthorized change.

CONTINGENT AND LIMITING CONDITIONS: The certification of the Appraiser appearing in the appraisal report is subject to the following conditions and to such other specific and limiting conditions as are set forth by the Appraiser in the report.

1. The Appraiser assumes no responsibility for matters of a legal nature affecting the property appraised or the title thereto, nor does the Appraiser render any opinion as to the title, which is assumed to be good and marketable. The property is appraised as though under responsible ownership.

2. Any sketch in the report may show approximate dimensions and is included to assist the reader in visualizing the property. The Appraiser has made no survey of the property.

3. The Appraiser is not required to give testimony or appear in court because of having made the appraisal with reference to the property in question, unless arrangements have been previously made therefore.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

4. Any distribution of the valuation in the report between land and improvements applies only under the existing program of utilization. The separate valuations for land and building must not be used in conjunction with any other appraisal and are invalid if so used.

5. The Appraiser assumes that there are no hidden or unapparent conditions of the property, subsoil, or structure, which would render it more or less valuable. The Appraiser assumes no responsibility for such conditions, or for engineering which might be required to discover such factors.

6. Information, estimates, and opinions furnished to the Appraiser, and contained in the report, were obtained from sources considered reliable and believed to be true and correct. However, no responsibility for accuracy of such items furnished the Appraiser can be assumed by the Appraiser.

7. Disclosure of the contents of the appraisal report is governed by the Bylaws and Regulations of the professional appraisal organizations with which the Appraiser is affiliated.

8. Neither all, nor any part of the content of the report, or copy thereof (including conclusions as to the property value, the identity of the Appraiser, professional designations, reference to any professional appraisal organizations, or the firm with which the Appraiser is connected), shall be used for any purposes by anyone but the client specified in the report, the borrower if appraisal fee paid by same, the mortgagee or its successors and assigns, mortgage insurers, consultants, professional appraisal organizations, any state or federally approved financial institution, any department, agency, or instrumentality of the United States or any state or the District of Columbia, without the written consent and approval of the Appraiser.

9. On all appraisals, subject to satisfactory completion, repairs, or alterations, the appraisal report and value conclusion are contingent upon completion of the improvements in a workmanlike manner.

Brad Dean
Certified General Appraiser #2544

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

PART III. GENERAL INFORMATION

THIS INSTRUMENT PREPARED BY
RAINEY, KIZER, REVIERE & BELL, P.L.C.
Attorneys at Law (70007-WCB)
105 S. Highland Avenue
Jackson, Tennessee 38301

PROPERTY OWNER
& ADDRESS:

West Tennessee Healthcare, Inc.
616 W. Forest Avenue
Jackson, TN 38305

PERSON OR ENTITY RESPONSIBLE
FOR THE PAYMENT OF REAL
PROPERTY TAXES & ADDRESS:
West Tennessee Healthcare, Inc.
620 Skyline Drive
Jackson, TN 38301

Without Survey or Title Examination

I, OR WE, HEREBY SWEAR OR AFFIRM THAT THE ACTUAL CONSIDERATION FOR THIS TRANSFER OR VALUE OF THE PROPERTY TRANSFERRED, (WHICHEVER IS GREATER) IS $ Exempt

William O'Neal Jr.
AFFIANT

SUBSCRIBED AND SWORN TO BEFORE ME THIS THE 1st DAY OF December, 2008.

Mary Ann Cooper

MARY ANN COOPER
STATE OF TENNESSEE
NOTARY PUBLIC
MADISON COUNTY, TENN.

COMMISSION EXPIRATION: July 6, 2010

Map 66M, Group J, Parcels 39.00, 1.00, 34.00 and 33.00

WARRANTY DEED

KNOW ALL MEN BY THESE PRESENTS: That THE JACKSON CLINIC BUILDING LIMITED PARTNERSHIP, a Tennessee limited partnership, ("Grantor") for and in consideration of the sum of One Hundred ($100.00) Dollars, cash in hand paid, and other good and satisfactory consideration, receipt of all of which is hereby acknowledged, has this day bargained and sold, and does hereby alien, transfer, and convey unto WEST TENNESSEE HEALTHCARE, INC., a Tennessee nonprofit corporation and governmental instrumentality of Jackson-Madison County General Hospital District, ("Grantee") those certain lots and/or parcels of real estate lying and being in the Fifth Ward of the City of Jackson, Madison County, Tennessee, and more particularly bounded and described on the attached EXHIBIT A.

TO HAVE AND TO HOLD the above-described real estate, together with all

Madison County Assessor
Map 66M GP J Par 39 Etal CP ___ PR ___

Book D696 Page 1583 Value Ø Date 12-1-08

easements and appurtenances thereunto belonging, unto the said WEST TENNESSEE HEALTHCARE, INC., its transferees, successors and assigns forever.

The Grantor covenants that it is lawfully seized and possessed of the above property; that it has full right to sell and convey the same as aforesaid; that said property is free of all liens and encumbrances with the exception of those matters as set forth on EXHIBIT B to which this conveyance is made subject.

With such exceptions Grantor will forever warrant and defend the title to said property unto the Grantee, its transferees, successors and assigns, against the lawful claims of all persons whomsoever.

IN WITNESS WHEREOF, the Grantor has caused its name to be hereunto subscribed by its authorized officer on this the 1 day of December, 2008.

THE JACKSON CLINIC BUILDING LIMITED PARTNERSHIP

By: JACKSON CLINIC, P.A., its General Partner
By: Kevin P. McMahon
Title: General Counsel

STATE OF TENNESSEE
COUNTY OF

Before me personally appeared Kevin P. McMahon, with whom I am personally acquainted, (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged such person to be General Counsel of the JACKSON CLINIC, P.A., the General Partner of THE JACKSON CLINIC BUILDING LIMITED PARTNERSHIP, the within named grantor, a partnership, and that such person, as such partner, executed the foregoing instrument for the purposes therein contained, by personally signing as the General Counsel of the General Partner of the THE JACKSON CLINIC BUILDING LIMITED PARTNERSHIP.

Witness my hand this 1 day of December, 2008.

DONALD D. GLENN NOTARY PUBLIC STATE OF TENNESSEE NOTARY PUBLIC MADISON COUNTY

My commission expires: 9/18/12

EXHIBIT A

Lying and being in the Fifth Civil District of Madison County, Tennessee, to-wit:

TRACT I:
BEGINNING at a stake in the south margin of Forest Avenue (formerly Omar Road) at a point 254 feet west of the northeast corner of a 12 acre tract of W.A. Hall, of which this tract is a part, and being 30 feet west of the northwest corner of the gin lot which was conveyed from said 12 acre tract by deed of record in Deed Book 117, page 503, runs thence west with the south margin of said Forest Avenue 354 feet to a stake at the northeast corner of Reams' lot; runs thence south 150 feet to a stake; runs thence west 90 feet to center of ditch; runs thence with ditch south 16 degrees 165 feet; thence south 11 degrees west 792 feet; runs thence north 64 degrees east 396 feet; thence north 55 degrees east 175 feet; thence leaving ditch north 4 degrees east 820 feet to the point of beginning containing 8.8 acres. Description taken from prior deed.

INCLUDED IN THE ABOVE DESCRIBED TRACT BUT EXPRESSLY EXCLUDED is the following tract of land conveyed to Wychmere Corporation by deed recorded in Deed Book 219, page 496, in the Register's Office of Madison County, Tennessee, and described as follows:
BEGINNING at a stake in the west margin of Forest Cove, said stake being south 4 degrees 17 minutes west 442.5 feet from the south margin of West Forest Avenue, said point also being at the southeast corner of the 4.0 acre tract of The Jackson Clinic as shown on the plat of the Forest Cove Subdivision, said subdivision plat having been placed of record in the Register's Office of Madison County, Tennessee, immediately preceding the filing of this instrument for recording; runs thence north 89 degrees west with the south line of said Jackson Clinic 4.0 acre tract 407.0 feet to a stake in the center of a sand ditch; runs thence south 15 degrees 13 minutes west with the center of said ditch 158.3 feet to a stake; runs thence south 9 degrees 37 minutes west with the center of said ditch 500.0 feet to a stake in the center of another sand ditch; runs thence north 49 degrees east with the center of said ditch 266.0 feet to a stake; runs thence north 70 degrees east with the center of said ditch 192.2 feet to a stake; runs thence north 40 degrees east with the center of said ditch 160.0 feet to a stake; runs thence north 70 degrees east with the center of said ditch 29.0 feet to a stake; runs thence north 4 degrees 17 minutes east leaving said ditch 160.0 feet to a stake in the south margin of the cul-de-sac of Forest Cove; runs thence in a northwesterly direction with the margin of said Forest Cove following a curve having a radius of 50 feet, a distance of 120.59 feet to a stake; runs thence in a northeasterly direction with the west margin of Forest Cove following a curve having a radius of 25 feet, a distance of 21.03 feet to the point of beginning, containing 4.6 acres, more or less, as surveyed by E. R. Dike & Son, Civil Engineers, on November 18, 1964.

TRACT II:
BEGINNING at a stake in the south margin of Forest Avenue Extended and in a ditch, said stake being at the northwest corner of the Hall tract; runs thence east with the south margin of Forest Avenue 136 feet to a stake; thence south 150 feet to a stake; thence west 70 feet to a ditch; thence with said ditch in a northwesterly direction 165 feet to the point of beginning. Description taken from prior deed.

Being part of the same property conveyed to The Jackson Clinic Building Limited, a limited partnership, by Quitclaim Deed dated March 2, 1981, appearing of record in Deed Book 412, page 203, in the Register's Office of Madison County, Tennessee, and being the same property

conveyed to The Jackson Clinic Building, Limited, a limited partnership, by Quitclaim Deed dated October 16, 1972, appearing of record in Deed Book 279, page 121, in said Register's Office.

TRACT III:
All of that property lying east of the eastern boundary of Lot No. 2 as described in the plat dated October 4, 1983, No. 1448-66-M prepared by McAlexander Engineering entitled "Plat of Property - The Jackson Clinic" attached hereto as Appendix 1 and incorporated herein ("Plat"), including all of grantor's interest as a riparian owner of and with respect to that certain ditch running along or near the east line of said Lot No. 2, being also Lot No. 2 of JOHN. Omar Subdivision, Block II, a plat and revised plat of which property appears of record in Plat Book 1, page 205, and Plat Book 1, page 211, respectively, in the Register's Office of Madison County, Tennessee. Description taken from prior deed.

Being the same property conveyed to The Jackson Clinic Building Limited, a limited partnership, by Quitclaim Deed dated October 27, 1983, appearing of record in Deed Book 437, page 259, in the Register's Office of Madison County, Tennessee.

TRACT IV:
All of that property lying east of the eastern boundary of Lot No. 3 as described in the Plat attached hereto as Appendix 1, including all of grantor's interest as a riparian owner of that certain ditch running along or near the east line of said Lot No. 3 of J. H. Omar Subdivision, specifically Lot 3, Block II, a plat and revised plat of which property appears of record in Plat Book 1, page 205, and Plat Book 1, page 211, in the Register's Office of Madison County, Tennessee. Description taken from prior deed.

Being the same property conveyed to The Jackson Clinic Building Limited, a limited partnership, by Quitclaim Deed dated October 19, 1983, appearing of record in Deed Book 437, page 261, in the Register's Office of Madison County, Tennessee.

Map 66M Group J Parcel 39.00

TRACT V:
Beginning in the northeast corner of a tract of land conveyed to J. H. Omar by R. B. Hicks and wife by deed appearing of record in the Register's Office of Madison County, Tennessee, in Deed Book 65, page 583, of which this lot is a part, said beginning point being also in the south margin of Forest Avenue (formerly Omar Lane), and runs thence west with its north line 91 feet to a stake at the northeast corner of a lot conveyed to L.A. Bugg and wife; thence south with said Bugg's east line 236 feet to a stake at Bugg's southeast corner; thence east 154 feet to a stake in a ditch or gully on the east line of the tract conveyed to Omar by Hicks; thence in a northwesterly direction with the meanderings of said ditch or gully to the point of beginning. Description taken from prior deed.

TRACT VI:
Beginning at a stake at the northwest corner of the tract of land conveyed to Robert L. Paschall and wife by T. D. Barham and wife on January 28, 1943, by deed recorded in the Register's Office of Madison County, Tennessee, and in the south margin of Forest Avenue (formerly Omar Lane), and runs thence east 50 feet to a stake; thence south 236 feet to a stake, a corner with Paschall; thence west 50 feet to a stake, the southwest corner of the original Barham tract; thence north 236 feet to the beginning; this being the western 50 feet of the tract above referred to. Description taken from prior deed.

Being the same property conveyed to Jackson Clinic Building Limited, a limited partnership by deed dated March 21, 1974, appearing of record in Deed Book 299, page 202, in the Register's Office of Madison County, Tennessee.

TRACT VII:
BEGINNING at a stake in the east margin of Linda Vista Drive, at the southwest corner of the Ramsey Lot, said Beginning point being about 236 feet south of West Forest Avenue; runs thence east with the south line of said Ramsey lot 194 feet to the west bank of said ditch; thence in a southeasterly direction with the bank of said ditch to the northeast corner of Lot 2, Block 2, of the John H. Omar Subdivision, a plat of which appears of record in Plat Book 1, page 211, in the Register's Office of Madison County, Tennessee; thence west with the north line of Lot No. 2 in said block 200 feet to its northwest corner of Linda Vista Drive; thence north 80 feet to the point of beginning, and being Lot No. 1 in Block 2 of said Subdivision. Description taken from prior deed.

Being the same property conveyed to Jackson Clinic Building Limited, a limited partnership by deed dated August 15, 1983, appearing of record in Deed Book 435, page 731, in the Register's Office of Madison County, Tennessee.

Map 66M Group J Parcel 1.00

TRACT VIII:
BEGINNING at a stake the south margin of West Forest Avenue at the northwest corner of the Wooten Subdivision; runs thence west with the south margin of West Forest Avenue 224 feet to a stake; thence south 4 degrees west 150 feet to a stake; thence in an easterly direction 199 feet to a stake in the Wooten Subdivision west line; thence in a northerly direction with the west margin of the Wooten Subdivision west line 155 feet, more or less to a stake in the south margin of West Forest Avenue to the point of beginning, and being that tract of land conveyed by Weeks and Hammond to Lett and Hammond by deed of record in Deed Book 149, page 324 in the Register's Office of Madison County, Tennessee. Raymond C. Hammond being deceased and Allene Fain Hammond, now also deceased, having inherited same under the Will of Raymond C. Hammond, and further conveyed to H.J. Lett and wife, Grace C. Lett by deed of the First National Bank of Jackson, Trustee in under the Will of Allene Fain Hammond, Will Book N, page 354, in the Office of the County Court Clerk of Madison County, Tennessee, said deed of record in Deed Book 281, page 439, in the Register's Office of Madison County, Tennessee. Description taken from prior deed.

TRACT IX:
BEGINNING at a stake in the south margin of a public road known as West Forest Avenue, said point being 224 feet west of the northwest corner of the Wooten Subdivision and at the northwest corner of what is commonly called the Hicksville Gin lot, and runs thence west with the south margin of Forest Avenue 5 feet to a stake in the east margin of Forest Cove; thence south 4 degrees west with the east line of Forest Cove 450 feet to a stake at the beginning of a curve to the southeast of the cul-de-sac; thence 130 feet, more or less, around the curve of said cul-de-sac to the centerline extended of Forest Cove; thence south 4 degrees west with the centerline extended 130 feet, more or less, to the north margin of a ditch; thence with the ditch north 62 degrees east 197 feet to a stake at the southwest corner of the Wooten Subdivision; thence north 13 degrees 10 minutes east with the west line of Wooten tract 424 feet to a stake at the southeast corner of the Hicksville Gin lot; thence west 199 feet with the south line of the gin lot to a stake at the southwest corner of said gin lot; thence north 4 degrees east 150 feet with the west line of the gin lot to the

point of beginning, and being a portion of that property conveyed to Mrs. Grace C. Lett by deed of record in Deed Book 176, page 331 in the Register's Office of Madison County, Tennessee.

Since the herein conveyed property was acquired by H.J. Lett and wife, Grace C. Lett and Raymond Hammond, a plat was recorded of the Forest Cove Subdivision in Plat Book 2, page 101, in the Register's Office of Madison County, Tennessee, wherein a roadway designated as Forest Cove was dedicated for public use. A portion of the property acquired by grantor Mrs. Grace C. Lett in Deed Book 176, page 331, Register's Office of Madison County, Tennessee, was used for the said roadway and it is the intention of the grantors to convey to grantee all the property acquired in Deed book 149, page 324, Deed Book 281, page 439 and Deed Book 176, page 331, in the Register's Office of Madison County, Tennessee, and bounded on the north by Forest Avenue, bounded on the west by Forest Cove and Medicenter, bounded on the south by a ditch and bounded on the east by lots 12, 13, 14, 15 and 16 of the Wooten Addition Subdivision recorded in Plat Book 1, page 173, in the Register's Office of Madison County, Tennessee.
Description taken from prior deed.

Being part of the same property conveyed to The Jackson Clinic Building, Limited, a limited partnership, by Quitclaim Deed dated March 2, 1981, appearing of record in Deed Book 412, page 203, in the Register's Office of Madison County, Tennessee, and being the same property conveyed to The Jackson Clinic Building Limited, a limited partnership, by Deed dated January 2, 1973, appearing of record in Deed Book 281, page 441, and corrected by Deed of Correction dated March 20, 1973, appearing of record in Deed Book 287, page 345, in said Register's Office.

TRACT X:
BEGINNING at a stake in the West margin of Lambuth Boulevard at a point five feet south of the Southeast corner of Lot #12 of the Wooten Addition, said point being the Southeast corner of a five foot strip off of Lot #13 in said subdivision, conveyed by Frank W. Young and wife to W. G. Taylor; runs thence West 177.5 feet to a stake; thence in a Southerly direction to a stake in the Northwest corner of Lot #14 in said Wooten Addition; thence East with the North line of Lot #14, 195 feet to the West margin of Lambuth Boulevard, 70 feet to the beginning. Description taken from prior deed.

Being the same property conveyed to The Jackson Clinic Professional Association, by deed dated December 30, 1975, appearing of record in Deed Book 322, page 384, in the Register's Office of Madison County, Tennessee. The Jackson Clinic Professional Association conveyed its interest to Jackson Clinic Building Limited, a limited partnership, by deed dated November 26, 2008, appearing of record in Book D696, page 1500, in the Register's Office of Madison County, Tennessee.

TRACT XI:
BEGINNING at an iron pin at the intersection of the south margin of West Forest Avenue and the west margin of Lambuth Boulevard, and runs thence west with the south margin of Forest Avenue 160 feet to an iron pin; runs thence in a southerly direction (South 12 degrees west) 82 feet, more or less, to an iron pin; thence east 177.5 feet to an iron pin in the west margin of Lambuth Boulevard; thence north with the west margin of Lambuth Boulevard 80 feet to the point of beginning. Being all of Lot No. 12 and the northern five feet of Lot No. 13 of the Wooten Addition to the City of Jackson, Tennessee, a plat of which appears of record in Plat Book 1, page 173, in the Register's Office of Madison County, Tennessee. The above description was taken from a survey made by E. R. Dike, C.E., on February 18, 1949. Description taken from prior deed.

Being the same property conveyed to Jackson Clinic Building Limited by deed dated April 20, 1981 appearing of record in Deed Book 408, page 486, in the Register's Office of Madison County, Tennessee.

Map 66M Group J Parcel 34.00

TRACT XII:
BEGINNING at a stake in the west margin of Lambuth Boulevard, at a point 150 feet south of the south margin of Forest Avenue, the southeast corner of Lot No. 13 of Wooten Addition to the City of Jackson, and runs thence west with the south line of said Lot No. 13, a distance of 195 feet to a stake; thence in a southerly direction 77 feet to a stake, the northwest corner of Lot No. 15 of said Subdivision; thence east with the north line of said Lot No. 15 a distance of 212.5 feet to a stake in the west margin of Lambuth Boulevard; thence north with the west margin of Lambuth Boulevard 75 feet to the point of beginning. Being designated as Lot No. 14 of the Wooten Addition to the City of Jackson, Tennessee, a plat of which appears of record in Plat Book 1, page 173, in the Register's Office of Madison County, Tennessee. Description taken from prior deed.

Being the same property conveyed to Jackson Clinic Building Limited by deed dated October 3, 1988, appearing of record in Deed Book 482, page 774, in the Register's Office of Madison County, Tennessee.

Map 66M Group J Parcel 33.00

The Jackson Clinic Building Limited Partnership, a Tennessee limited partnership, is one and the same as Jackson Clinic Building Limited, a Tennessee limited partnership, or any variation thereof.

EXHIBIT B

1. 2008 property taxes, which are to be prorated between the Grantor and Grantee herein as of the date of this instrument.

2. All matters affecting said lots appearing of record in Plat Book 1, page 173, Plat Book 1, page 211, and Plat Book 2, page 101, in the Register's Office of Madison County, Tennessee.

3. Easements for Electric Distributions Lines to the City of Jackson appearing of record in Deed Book 224, page 179, Deed Book 385, page 252, Deed Book 474, page 826, and Deed Book 534, page 572, all in the Register's Office of Madison County, Tennessee.

4. As to Tracts I, V and VII, Grant of Utility Easement to The City of Jackson appearing of record in Deed Book 441, page 582, in the Register's Office of Madison County, Tennessee.

5. As to Tracts II and V, Grant of Access Easement and Construction Easement to the Jackson-Madison County General Hospital District, for the purpose of operating, repairing and maintaining a pedestrian walkway over West Forest Avenue, dated February 3, 1998, appearing of record in Book D593, page 765, in the Register's Office of Madison County, Tennessee.

6. As to Tract II, Grant of Communications Systems Easement to West Tennessee Healthcare, Inc. dated December 1, 2004, appearing of record in Book D662, page 645, in the Register's Office of Madison County, Tennessee.

7. As to Tract IX, all rights of riparian owners in the ditch located on the south of subject property.

BK/PG:D696/1583-1590
08017661

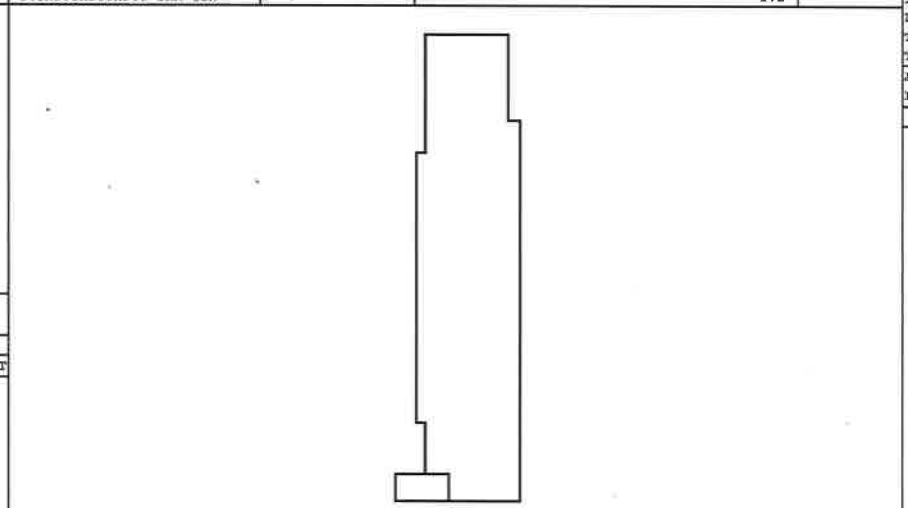
8 PGS : AL - DEED	
LINDA BATCH: 69924	
12/02/2008 - 12:12 PM	
VALUE	0.00
MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	40.00
DP FEE	2.00
REGISTER'S FEE	0.00
TOTAL AMOUNT	42.00

STATE of TENNESSEE, MADISON COUNTY
LINDA WALDON
REGISTER OF DEEDS

COMMERCIAL

PROPERTY ADDRESS	SUBDIV1	BK	PG	BL	LT	TAX YEAR		M J 0		01	066M	0.00		
FOREST AVE W 648						2014	DIST	MAP		GRP	CTLMAP	PARCEL	PI	SI
OWNER'S NAME & MAILING ADDRESS						COUNTY OF					DATE UPDATED			
WEST TENN HEALTHCARE INC	SUBDIV2					Madison					DATE PRINTED	10/27/2015		
	ADDITIONAL					TOTAL LAND UNITS					CARDS		OF	1
620 SKYLINE DR	DESCRIPTION					DEED			1.2				APPRAISED VALUE RECAP	
JACKSON TN 38301	DIMENSIONS	141X308X200X306 IRR COR				CALC			1.2				IMP	2800
													LAND	226400
													TOTAL APPR	229200
													TOTAL W/USE	0
													ASSESSMENT	91680
													PROP TYPE	08 40%

FOUNDATION	
FLOOR SYSTEM	HF
EXT WALL	PWF
STRUCT FRAME	
ROOF FRAMING	
ROOF COV DEC	
CAB MILLWORK	
FLOOR FINISH	RMS
INTER FINISH	PF
PAINT DECOR	WT/AREA
HTG/AIR COND	
PLUMBING FIX	BRF
BATH TILE	
ELECTRICAL	IMP TYPE
QUALITY	



AREA DIMENSIONS

BAS 3*100*3*19*8*10*24*141*4*32*28*44
OPF 10*10*18*10*8

TOTAL UNITS	SHAPE FAC	SIZE FAC	ADJ UNITS	BASE RATE	ADJ BASE	ACT YR BLT	EFF YR BLT

AREA DESC	PCT RATE	ADJ SF RT	AREA RATE	SQ FT	REPL COST

TOTAL AUX AREAS: | TOT BASE AREA | No STOR

DEPRECIATION AGE	NORM	OTHR	FUNC	ECON	% COND	REPL COST NEW	DEPR	DEPR VAL
		0	0	0				

XFSB DESC	QUAL	SIZE	UNIT PRICE	UNITS	EF YR BUILT	ANN DEPR	PERCNT COND
ASPHALT PAVING	1	20000	0.00	0	1995	0.00	0.00

XFSB APPR DATE | APP BY | TOTAL XFSB VALUE 2840

GENERAL PARCEL DATA

LND APP	BY	SSD	WARD	EDD	PLAN	OTR	MORT	MH	MH NO	AREA CODE
2009-08-01	88									J48

PARCEL STAT	DIST TREND	TOPO	TYPE OWNER	ROAD NO	ROAD TYPE	CONST CODE	SUBD TRACT	N-S COORD	E-W COORD
	2	1			8			-88.82	35.63

CENSUS TRACT	BLOCK	BLK FACE	AREA	CON DIST	OPTIONAL
000300	3				

GENERAL CARD DATA

BLDG APP	APP BY	SOURCE	DWL UNITS	WAT	SEW	ELEC	GAS	ZONING	OCC	COND
				1	1	1	4	22		

PERMIT NO	PHA NO	RENTAL SOURCE	RENTAL AMT	RENT SCHED
	0		0	

LAND DESC	DESC CODE	DIMS	SOIL	UM	FLD	LOC	SIZE	DEPT FAC	COND FAC	UNIT LAND PRICE	ADJ UNIT LAND PRICE	LAND UNITS	MARKET LAND VALUE	COND FAC	LAND USE UNIT PRICE	USE LAND VAL
COMMERCIAL		141 X 308								0.00	0.00					

Microsoft VBScript runtime error '800a000d'

Type mismatch: 'CInt'

/classic/prc/PropCard5.asp, line 1204

SUPPLEMENTAL #2
November 12, 2015
11:52 am

COMMERCIAL

PROPERTY ADDRESS	SUBDIV1	BK	PG	BL	LT	TAX YEAR		M J 0	39	066M	0.00		
W FOREST AVE 615						2014	DIST	MAP	GRP	CTLMAP	PARCEL	PI	SI
OWNER'S NAME & MAILING ADDRESS		2	101			COUNTY OF				DATE UPDATED			
WEST TENN HEALTHCARE INC	SUBDIV2					Madison				DATE PRINTED	10/27/2015		
	ADDITIONAL DESCRIPTION					TOTAL LAND UNITS				CARDS	1	OF	1
620 SKYLINE DR	DIMENSIONS					DEED		4.3				APPRAISED VALUE RECAP	
JACKSON TN 38301						CALC		4.3				IMP	4933000
												LAND	608600
												TOTAL APPR	5541600
												TOTAL W/USE	0
												ASSESSMENT	2216640
												PROP TYPE	08 40%
												AREA DIMENSIONS	

FOUNDATION	SPECIAL FOOTING						
FLOOR SYSTEM	SLAB ABOVE GRADE	HF	0				
EXT WALL	COMMON BRICK	PWF	0				
STRUCT FRAME	CONCRETE REINFORCED						
ROOF FRAMING	REINFORCED CONCRETE						
ROOF COV DEC	BUILT-UP/METAL GYPSUM						
CAB MILLWORK	ABOVE AVERAGE						
FLOOR FINISH	CARPET COMBINATION	RMS					
INTER FINISH	DRYWALL	PF	0				
PAINT DECOR	ABOVE AVERAGE	WT/AREA					
HTG/AIR COND	HEAT SPLIT	0					
PLUMBING FIX	215	BRF					
BATH TILE		0					
ELECTRICAL	ABOVE AVERAGE	IMP TYPE					
QUALITY	ABOVE AVERAGE +	20					

TOTAL UNITS	SHAPE FAC	SIZE FAC	ADJ UNITS	BASE RATE	ADJ BASE	ACT YR BLT	EFF YR BLT
0				0	0	1950	1950

AREA DESC	PCT RATE	ADJ SF RT	AREA RATE	SQ FT	REPL COST

TOTAL AUX AREAS:	86991	TOT BASE AREA	0	No STOR	2

DEPRECIATION						REPL COST		
AGE	NORM	OTHR	FUNC	ECON	% COND	NEW	DEPR	
64	40	0	0	0		12269450	4907780	

XFSB DESC	QUAL	SIZE	UNIT PRICE	UNITS	EF YR BUILT	ANN DEPR	PERCNT COND	DEPR VAL
ASPHALT PAVING	1	110000	0.00	0	1984	0.00	0.00	15620
DETACHED GARAGE FINISHED	1	20X20	0.00	0	1998	0.00	0.00	9600

XPSB APPR DATE | APP BY | TOTAL XFSB VALUE 25220

GENERAL PARCEL DATA

LND APP	BY	SSD	WARD	EDD	PLAN	QTR	MORT	MH	MH NO	AREA CODE
2009-08-01	88									J48

PARCEL STAT	DIST TREND	TOPO	TYPE OWNER	ROAD NO	ROAD TYPE	CONST CODE	SUBD TRACT	N-S COORD	E-W COORD
	2	1			8			-88.82	35.63

CENSUS TRACT	BLOCK	BLK FACE	AREA	CON DIST	OPTIONAL
000300	3				

GENERAL CARD DATA

BLDG APP	APP BY	SOURCE	DWL UNITS	WAT	SEW	ELEC	GAS	ZONING	OCC	COND
				1	1	1	4	22	Y	A

PERMIT NO	FHA NO	RENTAL SOURCE	RENTAL AMT	RENT SCHED
	0		0	

LAND DESC	DESC CODE	DIMS	SOIL	UM	FLD	LOC	SIZE	DEPT FAC	COND FAC	UNIT LAND PRICE	ADJ UNIT LAND PRICE	LAND UNITS	MARKET LAND VALUE	COND FAC	LAND USE UNIT PRICE	USE LAND VAL
COMMERCIAL										0.00	0.00					

Microsoft VBScript runtime error '800a000d'

Type mismatch: 'CInt'

/classic/prc/PropCard5.asp, line 1204

SUPPLEMENTAL #2
November 12, 2015
11:52 am

Courthouse Retrieval System - Madison County, TN
Report on Parcel :066M J 001.00 Generated :10/27/2015

General Information

WEST TENN HEALTHCARE INC

620 SKYLINE DR
JACKSON, TN 38301

Parcel ID:	066M J 001.00	Special Int:		Land C Map:	
Alt-Parcel ID:	057066M J 00100 00005066M	Map Sort::	066M J 001.00	Acct No:	
Subdivision		Plat Book:		Page:	
Property Address:	648 W FOREST AVE	Subdv Block:		Lot:	
	JACKSON, TN 38301-3902	Parcel:	0	District:	05
Telephone:	()-	SSD1:		SSD2:	
		Ward:	05		

Land Value:	226400	Dimensions:	141X308X200X306 IRR COR	Description:	
Improvement Value:	2800	Acreage:	1.2	Property Type:	COMMERCIAL
Total Value:	229200	Square Feet:		Land Use:	82 PERSONAL SERVICES
Assessed Value:	91680	Geo Code:	35.63499721 : -88.82954366	Improvement Type:	-
City Tax:	1798.67	Census Tract:	3	Zoning Code:	22 B1
County Tax:	1971.12	Census Block:	3	Owner Type:	
Total Tax:	3769.79	Gas Source:	PUBLIC - NATURAL GAS	Road Type:	CURB/GUTTER PAVED
Last Sale Date:	2008-12-01	Electric Source:	PUBLIC	Topography:	LEVEL
Last Sale Amount:		Water Source:	PUBLIC	District Trend:	IMPROVING
Book/Page:	696/ 1583	Sewer Source:	PUBLIC		
Document No:					
Exemption Amount:					
Exemption Reason:					

Land Data For Parcel

Land Type	Land Size	Land Amount	Land Use
COMMERCIAL	1.2 AC	226440	

Building Information - No Building Data Available for Parcel: 066M J 001.00

Extra Features

Description	Size	Year Built	Condition
ASPHALT PAVING	20000	1995	AVERAGE

Sales & Deed History

Sales Data

Date:	2008-12-01	Amount:		Instrument:	-na-
Owner:	WEST TENN HEALTHCARE INC			Quality:	
Book:	696	Page:	1583		
Document No:					
Date:	1974-03-22	Amount:		Instrument:	-na-
Owner:	JACKSON CLINIC BLDG LIMITED			Quality:	

Deed Data

No Deed Data Available for Parcel...

Book: 299	Page: 202
Document No:	

Trust Deed Information - No Trust Deed Data Available for Parcel: 066M J 001.00

Courthouse Retrieval System - Madison County, TN
Report on Parcel :066M J 039.00 Generated :10/27/2015

General Information

WEST TENN HEALTHCARE INC

620 SKYLINE DR
JACKSON, TN 38301

Parcel ID:	066M J 039.00	Special Int:		Land C Map:	
Alt-Parcel ID:	057066M J 03900 00005066M	Map Sort::	066M J 039.00	Acct No:	
Subdivision		Plat Book:	2	Page:	101
Property Address:	616 W FOREST AVE	Subdv Block:		Lot:	
	JACKSON, TN 38301-3902	Parcel:	0	District:	05
Telephone:	()-	SSD1:		SSD2:	
		Ward:	05		

Land Value:	608600
Improvement Value:	4933000
Total Value:	5541600
Assessed Value:	2216640
City Tax:	43488.26
County Tax:	47657.76
Total Tax:	91146.02
Last Sale Date:	2008-12-01
Last Sale Amount:	
Book/Page:	696/ 1583
Document No:	
Exemption Amount:	
Exemption Reason:	

Dimensions:	
Acreage:	4.3
Square Feet:	86991
Geo Code:	35.63483064 : -88.82851322
Census Tract:	3
Census Block:	3
Gas Source:	PUBLIC - NATURAL GAS
Electric Source:	PUBLIC
Water Source:	PUBLIC
Sewer Source:	PUBLIC

Description:	
Property Type:	COMMERCIAL
Land Use:	85 PROFESSIONAL SERVICES
Improvement Type:	20 -MEDICAL OFFICE
Zoning Code:	22 B1
Owner Type:	
Road Type:	CURB/GUTTER PAVED
Topography:	LEVEL
District Trend:	IMPROVING

Land Data For Parcel

Land Type	Land Size	Land Amount	Land Use
COMMERCIAL	4.3 AC	608560	

Building Information

Building Number:1

Improvement Type:	20-MEDICAL OFFICE		
Condition:	AVERAGE		
Occupancy:	OCCUPIED		
Last Appraisal Date:			
Year Built:	1950	Effective Year:	1950
Building Data Source:	AGENT		
Structural Framing:	CONCRETE REINFORCED		
Foundation:	SPECIAL FOOTING		
Floor System:	SLAB ABOVE GRADE		
Exterior Wall:	COMMON BRICK		
Common Wall:			
Roof Framing:	REINFORCED CONCRETE		
Roof Cover Deck:	BUILT-UP/METAL GYPSUM		
Cabinet Mill Work:	ABOVE AVERAGE		
Floor Finish:	CARPET COMBINATION		
Interior Finish:	DRYWALL		
Heat & Air:	HEAT SPLIT		

Bedrooms:	
Full Bathrooms:	
Half Bathrooms:	
Total Rooms:	
Stories:	2
Dwelling Units:	
Partitions:	
Plumbing Fixtures	215
Fireplace?	

Dimensions	
Total Area	86991
Base Area	0

Air Conditioning:	COOLING SPLIT
Bathroom Tile:	
Building Quality:	ABOVE AVERAGE +
Building Shape:	IRREGULAR SHAPE

Extra Features

Description	Size	Year Built	Condition
ASPHALT PAVING	110000	1984	AVERAGE
DETACHED GARAGE FINISHED	20X20	1998	AVERAGE

Sales & Deed History

Sales Data

Date:	2008-12-01	Amount:		Instrument:	-na-
Owner:	WEST TENN HEALTCARE INC			Quality:	
Book:	696	Page:	1583		
Document No:					
Date:	1983-10-27	Amount:		Instrument:	-na-
Owner:	JACKSON CLINIC BLDG LTD THE			Quality:	
Book:	437	Page:	259		
Document No:					
Date:	1983-10-19	Amount:		Instrument:	-na-
Owner:				Quality:	
Book:	437	Page:	261		
Document No:					
Date:	1981-03-02	Amount:		Instrument:	-na-
Owner:				Quality:	
Book:	412	Page:	203		
Document No:					
Date:	1972-10-16	Amount:		Instrument:	-na-
Owner:				Quality:	
Book:	189	Page:	400		
Document No:					

Deed Data

No Deed Data Available for Parcel...

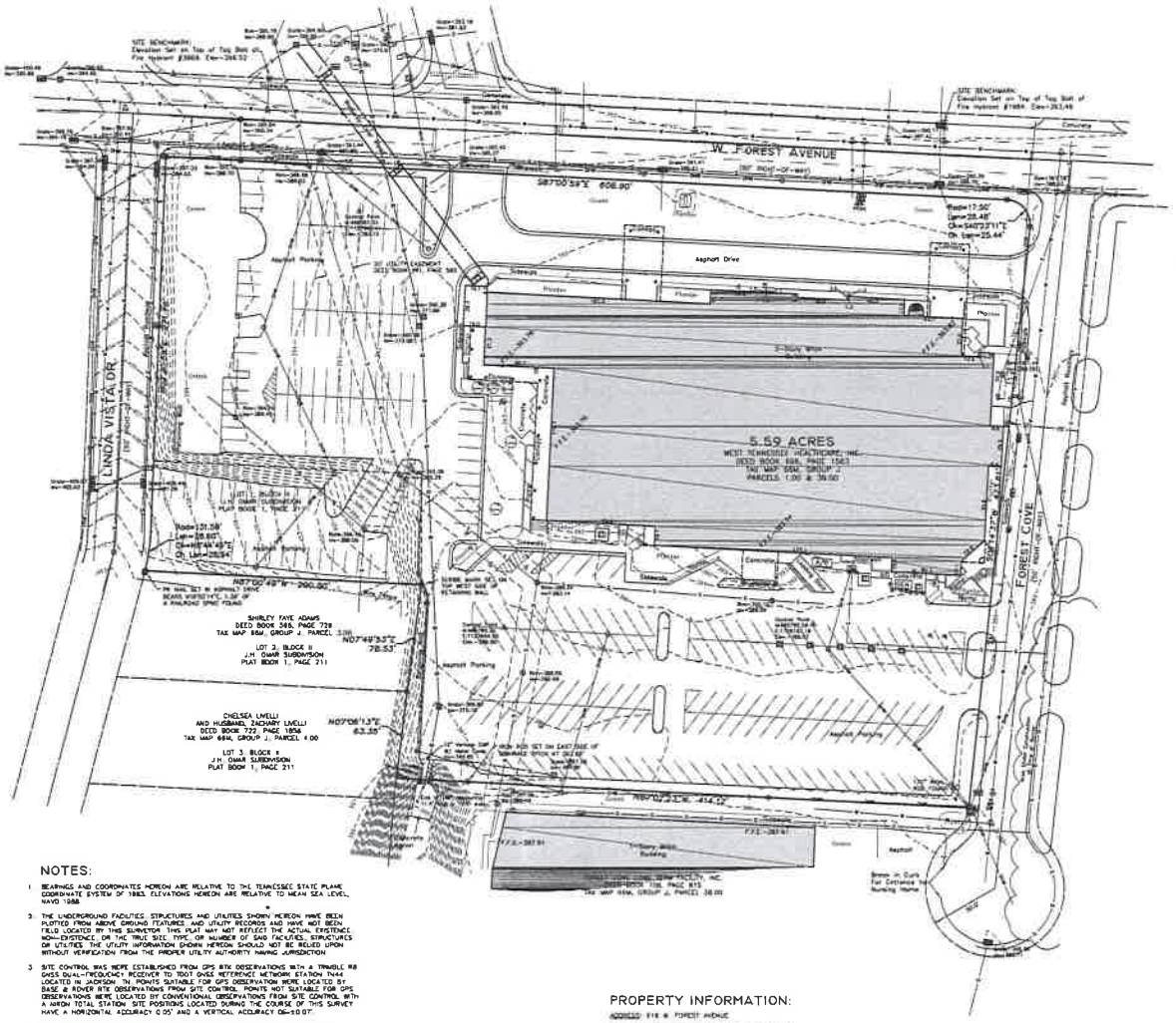
Trust Deed Information - No Trust Deed Data Available for Parcel: 066M J 039.00

SUPPLEMENTAL #2

November 12, 2015

29

Parking Spaces
Regular Spaces = 222
Handicap Spaces = 6
Total Spaces = 228



LOCATION MAP
(NOT TO SCALE)

GRAPHIC SCALE
40 0 20 40 80
SCALE: 1"=40'

LEGEND

- SSCO = SEWER CLEANOUT
- SSMH = SANITARY SEWER MANHOLE
- WM = WATER METER
- WV = WATER VALVE
- FH = FIRE HYDRANT
- IV = IRRIGATION VALVE
- FSV = FIRE SPRINKLER VALVE
- YI = YARD INLET
- CB/AI = CATCH BASIN / AREA INLET
- CI = CURB INLET
- GM = GAS METER
- GV = GAS VALVE
- TR = TELEPHONE RISER / BOX
- UP = UTILITY POLE
- LP = LIGHT POLE
- GW = GUY WIRE ANCHOR
- EM = ELECTRIC METER
- EB = ELECTRIC BOX
- ET = ELECTRIC TRANSFORMER
- AC = AIR CONDITIONING UNIT
- LP = LIGHT POLE / FLOOD LIGHT
- B = BOLLARD
- SIGN = SIGN
- CMP = CORRUGATED METAL PIPE
- TFE = TRANSITED FLOOR ELEVATION
- MH = MANHOLE
- RCP = REINFORCED CONCRETE PIPE
- TSPCS = TENNESSEE STATE PLANE COORDINATE SYSTEM (NAD83 = NORTH AMERICAN DATUM OF 1983)

Property Line; Adjoining Property Line; Building Setback Line; Easement Line; Water Line; Sanitary Sewer Pipe; Storm Drain Pipe; Gas Line; Overhead Utility Wire

1/2-inch iron rod with aluminum cap stamped "PLS INC" set ○ = Monument found as noted △ = Survey control point

NOTES:

1. BEARINGS AND COORDINATES HEREON ARE RELATIVE TO THE TENNESSEE STATE PLANE COORDINATE SYSTEM OF 1983. ELEVATIONS HEREON ARE RELATIVE TO MEAN SEA LEVEL, NAVD 1988.
2. THE UNDERGROUND FACILITIES, STRUCTURES AND UTILITIES SHOWN HEREON HAVE BEEN PLOTTED FROM ABOVE GROUND FEATURES AND UTILITY RECORDS AND HAVE NOT BEEN FIELD LOCATED BY THIS SURVEYOR. THIS PLAT MAY NOT REFLECT THE ACTUAL EXISTENCE NON-EXISTENCE, OR THE TRUE SIZE, TYPE, OR NUMBER OF SAID FACILITIES, STRUCTURES OR UTILITIES. THE UTILITY INFORMATION SHOWN HEREON SHOULD NOT BE RELIED UPON WITHOUT VERIFICATION FROM THE PROPER UTILITY AUTHORITY HAVING JURISDICTION.
3. SITE CONTROL WAS WERE ESTABLISHED FROM GPS RTK OBSERVATIONS WITH A TRIMBLE R8 GNSS DUAL-FREQUENCY RECEIVER TO TDOT GNSS REFERENCE NETWORK STATION TN44 LOCATED IN JACKSON TN. POINTS SUITABLE FOR GPS OBSERVATION WERE LOCATED BY BASE & ROVER RTK OBSERVATIONS FROM SITE CONTROL POINTS NOT SUITABLE FOR GPS OBSERVATIONS WERE LOCATED BY CONVENTIONAL OBSERVATIONS FROM SITE CONTROL WITH A ARRON TOTAL STATION. SITE POSITIONS LOCATED DURING THE COURSE OF THIS SURVEY HAVE A HORIZONTAL ACCURACY 0.05' AND A VERTICAL ACCURACY 0.06+0.07'.
4. THE INFORMATION SHOWN HEREON WAS DERIVED FROM RANDOM SHOTS TAKEN WITH ELECTRONIC SURVEY EQUIPMENT.
5. THIS SURVEY WAS PREPARED WITHOUT THE BENEFIT OF A TITLE EXAMINATION OR ABSTRACT OF TITLE. THIS SURVEYOR HAS MADE NO INDEPENDENT SEARCH AS TO COVENANTS, CONDITIONS OR EASEMENTS OF RECORD THAT A CURRENT TITLE EXAMINATION MAY DISCLOSE.
6. THIS PROPERTY IS NOT LOCATED WITHIN A SPECIAL FLOOD HAZARD ZONE AS SHOWN ON FLOOD INSURANCE RATE MAP OF MADISON COUNTY, MAP NUMBER #47113C0216E, HAVING AN EFFECTIVE DATE OF AUGUST 03, 2009.
7. THIS PROPERTY IS SUBJECT TO EASEMENTS FOR ELECTRIC DISTRIBUTION LINES AND DOWN GUYS OF RECORD IN DEED BOOK 224, PAGE 179, DEED BOOK 385, PAGE 253, DEED BOOK 474, PAGE 536, AND DEED BOOK 534, PAGE 572. THESE EASEMENTS ARE NOT PLOTTABLE AS DESCRIBED.
8. THIS PROPERTY IS SUBJECT TO A GRANT OF ACCESS EASEMENT AND CONSTRUCTION EASEMENT FOR A OVERHEAD PEDESTRIAN WALKWAY AND ELEVATOR TOWER AS RECORDED IN DEED BOOK 583, PAGE 765. THE EASEMENT PREMISES IS LOCATED WITHIN AND ABOVE THE RIGHT-OF-WAY OF FOREST AVENUE.

PROPERTY INFORMATION:

ADDRESS: 516 W. FOREST AVENUE

TOTAL AREA: 243,580 SQUARE FEET OR 5.59 ACRES

DEED REFERENCE: THAT PARCEL OF LAND TRANSFERRED UNTO WEST TENNESSEE HEALTHCARE, INC BY DEED OF RECORD IN DEED BOOK 696, PAGE 1583 IN THE REGISTER'S OFFICE OF MADISON COUNTY, TENNESSEE.

TAX PARCEL REFERENCE: TAX MAP 66M, GROUP J, PARCELS 1.00 & 39.00 IN THE PROPERTY ASSESSOR'S OFFICE OF MADISON COUNTY, TENNESSEE.

ZONING INFORMATION: THIS PROPERTY IS ZONED B-1 (MEDICAL AND RELATED SERVICES) DISTRICT. PER ZONING REGULATIONS, THE FRONT YARD SETBACK IS 30 FEET, THE SIDE YARD SETBACK IS 10 FEET AND THE REAR YARD SETBACK IS 25 FEET. THE MAXIMUM LOT COVERAGE BY PRINCIPAL AND ACCESSORY BUILDINGS IS 40% OF THE TOTAL LOT AREA AND THE MAXIMUM BUILDING HEIGHT IS 6 STORIES.

CERTIFICATE

THIS IS TO CERTIFY THAT THIS MAP OR PLAT AND THE SURVEY ON WHICH IT IS BASED WERE MADE IN ACCORDANCE WITH THE 2011 MINIMUM STANDARD DETAIL REQUIREMENTS FOR ALTA/ACSM LAND TITLE SURVEYS, JOINTLY ESTABLISHED AND ADOPTED BY ALTA AND NSPS, AND INCLUDES ITEMS 1, 2, 3, 4, 5, 8(a), 7(a), 8, 9, 11(a), 13, 14, 16, 17, AND 18 OF TABLE A THEREOF. THE FIELD WORK WAS COMPLETED ON SEPTEMBER 04, 2015.

R. BRENT DEAN
TENNESSEE R.L.S. 2305

Professional Land Services
LAND SURVEYING - MAPPING - PLANNING
118 Miller Avenue
Jackson, Tennessee 38305
Phone: (731) 668-7171 Fax: (731) 668-0775

PW Date: 10/30/15
Drawn By: VB/BD
Date Drawn: 10/30/15
Checked By: RD

FOR
TLM ASSOCIATES
117 E. LAFAYETTE ST.
JACKSON, TN 38301

ALTA/ACSM LAND TITLE SURVEY
OF A
5.59 ACRES PARCEL IN THE NAME OF
WEST TENNESSEE HEALTHCARE, INC
IN THE 8TH CIVIL DISTRICT OF THE CITY OF JACKSON
MADISON COUNTY, TENNESSEE

November 12, 2015

Job #: 15146
DWG File #: 15146
Scale: 1"=40'
SHT. 1 of 1

SUPPLEMENTAL #2

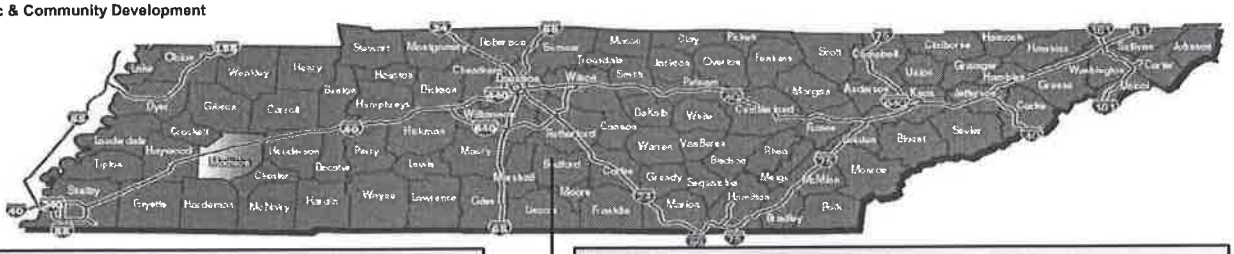
SUPPLEMENTAL #2

November 12, 2015

TENNESSEE COMMUNITY DATA SHEET

Jackson

Dept of Economic & Community Development



LOCATION

Mkt. Region: Jackson
County: Madison **Sq. Miles:** 561
Distance From:(City) Memphis **Miles:** 79
Nashville **Miles:** 126
MSA Name: Jackson, TN

POPULATION

	City	County
2009 (Estimates).....	59,643	91,837
2010 (Census).....	65,211	98,294
% Population Change for 2000-2010	9.30%	7.03%

TAX STRUCTURE

Local

Property Tax	City	County
Rate Per $100 Value.....	$1.9700	$2.1500
Ratio of Assessment		
Residential.....	**25%**	**25%**
Industrial.....	**40%**	**40%**
Personal (Equipment)	**30%**	**30%**
Bonded Debt.....	$75,679,785	$59,745,745
Sales Tax.....	275.00%	275.00%

State

Sales Tax..... 7% (5.25% for food and food ingredients for human consumption)

Income Tax

Personal..... 6% on Interest & Dividends

Excise..... 6.5% of Net Earnings

Franchise..... .25 per $100 of Capital Properties

Unemployment Tax

New Employers..... 2.7% of first $9,000

TRANSPORTATION FOR MADISON COUNTY

Railroads

Served by: CSX Transportation, West Tennessee Railroad (shortline)
Norfolk-Southern

Highways

0 Miles to Access of Interstate - 40

U.S. Highways: 70, 45, 412
State Highways: 18, 198, 223

Common Carriers

Air Freight Companies: 1

Motor Freight Companies: 35 **Terminal Facilities:** 35

Carrier Service: Yes

Navigable Waterway

River: Mississippi **Channel Depth:** 9'

Nearest Port: Memphis **Miles:** 80

Air Service

General Aviation/Distance: McKellar-Sipes Regional Airport

Location Identifier: MKL and IFR

Runway Lengths: 6,008' X 150' and 3,540'

Nearest Commercial Service: Memphis International

Location Identifier: MEM

Airlines Serving:
Served by 16 airlines operating to 89 markets and 49 non-stop markets

Daily Flights: 400

Jackson

EDUCATION

Type of Public School System: City/County

	# Local Schools	Enrollment
Elementary.....	14	5239
Middle/Jr. High	8	3644
Sr. High School.....	5	3863
Private &/or Parochial..	7	3700
Technology Centers.....	1	
Vo-Tech.....	0	
Colleges (2 & 4 year)..	4	10930
Libraries: 2		

High School Graduates (2009): 882

GOVERNMENT

Gov't (type): City: Mayor & City Council

County: County Mayor & Commissioners

Law Enforcement:	City	County
Police Officers:	202	251
Fire Department:		
Fire Stations:	6	16
Firefighters:	153	0
Volunteers:	0	166
Planning Commission:	Yes	Yes
Zoning Regulation:	Yes	Yes
Industrial Development Board:	Yes	Yes
Insurance Rating:	3	6

COMMUNITY FACILITIES

Day Care

Day Care Centers: 37 **Day Care Homes:** 17

Health Care

Hospitals.....	2	Beds: 789
Clinics.....	52	
Doctors.....	496	
Dentists.....	86	
Nursing Homes....	6	Beds: 656
Retirement Homes..	1	Beds: 11
Residential Care/Assisted Living:	5	Beds: 323

Churches

Protestant:	197
Catholic:	1
Jewish:	1
Other:	

Recreation

Parks.....	29	
Golf Courses.....	6	(Public & Private)
Country Clubs.....	1	

CLIMATE

Annual Avg. Temperature: 59.4°

Monthly Avg. High Temp: Jan. 46.4° Jul 90.4°

Monthly Avg. Low Temp: Jan. 28.0° Jul 69.3°

Annual Avg. Precipitation: 53.96"

Annual Avg. Snowfall: 3.5"

Elevation: 433' above sea level

Prevailing Winds: South-Southwest

Mean Length of Freeze Free Period (Days): 180-200

Jackson

SELECTED ECONOMIC INDICATORS FOR MADISON COUNTY

County Available Labor

Date: January 2011

Total: 5,280 **Male:** 2,610 **Female:** 2,670

Estimated Total in Surrounding Area: 17,810

Labor Force Estimates

Annual Avg. Employment	2009
Civilian Labor Force.....	48,370
Unemployment.....	4,840
%Unemployment Rate.....	10.0
Total Employment.....	43,540

Per Capita Income

Year	Amount
2007	$31,112.00

Retail Sales

Year	Amount
2010	$1,890,556,890

County 10-Year Manufacturing Growth

Years: 2000-2009	New Plants	Expansions
Number Projects:	9	143
Total Investments:	$282,100,000	$486,169,239

UTILITIES

Electricity

Electric Power System: Jackson Energy Authority

Gas

Gas Supplier: Jackson Energy Authority

Water

Water Supplier: Jackson Energy Authority

Capacity: 24,400,000 GPD

Current Consumption: 12665000 GPD

Storage Capacity: 16.75 MG

Sewer

Sewer Provider: Jackson Energy Authority

Type of Treatment: Trickling Filter & Activated Sludge

Capacity: 23400000 GPD

Current Usage: 13050000 GPD

% City Sewer Coverage: 100.0

% Storm Sewer Coverage: 99.0

Jackson

LARGEST COMPANIES IN MADISON COUNTY (by Employment Size)

Firm Name	Products/ Services	Total Employees	Union Affliations
West Tennessee Healthcare	Hospital/Healthcare	4362	None
Jackson-Madison County School System	Education	1582	None
Procter and Gamble Manufacturing Company	Pringles potato chips	824	None
The City of Jackson	City Government	806	None
Devilbiss Air Power Company	Air Compressors, Generators and Pressure Washers	650	None
Union University	Southern Baptist Liberal Arts University	637	None
The County of Madison	County Government	632	None
Delta Faucet Company	Commercial and Residental Faucets	600	None
Pinnacle Foods Group	Frozen Foods	592	None
Regional Hospital of Jackson	Hospital/Healthcare	574	None
Black & Decker	Professional Power Tools	537	None
Madison-Haywood Development Center	Education	450	None
Wal-Mart #335 (North)	Retail Store	446	None
Lane College	Liberal Arts University	412	None
Jackson Energy Authority	Utilities and Telecommunications	411	None
Jackson State Community College	Community College	403	None
Perseus Distribution	Book Distribution	400	None
TBDN Tennessee Company	Automotive Air and Oil Filters	390	None
Gerdau Ameristeel Corporation	Reinforced Steel and Merchant Bar Products	380	None
Armstong Wood Products	Hardwood Flooring	310	UBC/UOFA
Portfolio Recovery Associates	Outbound Call Center	305	None
UGN, Inc.	Automotive Supplier	300	None
Walmart #393 (South)	Retail	279	None
Aldelano Packaging Corporation	Contract Packaging	275	None
Easter Seals Tennessee	Nonprofit	267	None
Young Touchstone	Locomotive radiators and heat exchange equip.	265	None
SM Lawrence, Inc.	Electrical Contractors	250	None
The Jackson Sun	Newspaper Publishing and Printing	245	None
Duro Bag	Plastic Bags	245	None
Pathways	Mental Health	244	None
Owens Corning	Chopped Fiberglass	234	None
Kirkland's, Inc.	Corp HQ/Distribution Home Decor	230	None

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

HEALTHCARE TRENDS & DEMOGRAPHICS

We recognize the subject is located in a medical oriented area and has a highest and best use as vacant of being improved with a medical use property. The healthcare industry is in a transition period due to the impacts from several sea change issues. The Affordable Care Act (ACA) is accelerating the trend of health system and physician acquisitions, consolidations and alliances. Advancements in technology are profoundly altering the means of healthcare delivery and administration. Concurrent with these changes is the ballooning population of older Americans who will require more healthcare services, although the impact of this demographic trend varies significantly by local area. The net effect of these changes is rising demand for healthcare services, albeit amid ACA uncertainty, provider and consumer cost pressures, regional industry and demographic variations, and a greater need for flexibility given the accelerating rate of technological change.

The aging of the baby boomer population, defined as those born between 1946 and 1964, remains the primary long-term demographic driver of demand for medical services at the national level. Accordingto the most recent Census projections, population growth in the 65+year-old cohort is expected to remain higher than growth rates in the younger age cohorts through at least 2060, with particularly strong growth during the next 20 years. Through 2035, the 65+ cohort is projected to increase by two-thirds, or by more than 31 million people, to account for more than one-fifth of the U.S. population.

The growth in the older population will translate into a significant increase in healthcare spending. Based on conservative estimates, the 65+ population accounts for $0.50 of every $1 of healthcare spending. Also, medical and technological advancements are extending life expectancies and driving lifetime demand for healthcare services to unprecedented levels. In addition, baby boomers are opting for elective procedures, such as cosmetic and exploratory surgeries, as well as complementary and alternative medicine at a higher rate than previous generations. These trends will contribute to increased spending on healthcare given this cohort's disproportionate share of aggregate U.S. healthcare spending.

Although growth in the baby boomer population is driving healthcare demand across the U.S., the extent of the impact varies significantly by state, city and local community. At the state level, Alaska, Utah, Texas, North Dakota, Washington D.C., Colorado and California have the lowest percentages of residents aged 65 or higher. However, in absolute terms, California and Texas have the first- and third-highest populations in this age group, while Alaska, Washington D.C. and North Dakota also rank low according to this metric. Similarly, the most populous U.S. metropolitan areas dominate the list of markets projected to have the largest change in the 65+ population between 2014 and 2019. In percentage terms, Sunbelt and Western markets are expected to post the fastest growth in the 65+ population during the next five years. Local variations in demographics underscore the importance of a detailed, market-specific demographic analysis during healthcare site selection, development and investment. The other major demographic trend influencing the healthcare industry is the maturation of the millennial generation, defined as those born between 1980 and 1999. Because of the greater healthcare needs of the older population, the aging baby boomer population has captured most of the headlines with respect to healthcare industry growth. However, the millennial generation is actually slightly larger than the baby boomer population, at about 87 million millennials versus 76 million baby boomers, and millennials already are influencing the future of healthcare delivery. As the first generation to grow up with the

Source: Colliers International Medical Office Highlights 2015 Outlook

internet, millennials possess similar expectations for healthcare delivery as other aspects of their lives, including convenience and flexibility. They also are comfortable with sharing personal information electronically. In addition, many millennials will be involved with decisions regarding their aging parents' healthcare in the future and will demand technology to help them manage this care and information related to it.

The growing influence of the millennial generation is one reason for the large amount of capital entering the healthcare technology space and driving innovation in the industry. One example is ZocDoc, an online scheduling system that allows patients to make and modify appointments, research and review providers, and fill out paperwork online before the appointment. Another is One Medical, a primary care healthcare group that locates in urban residential and commercial areas proximate to its consumer baseand offers technological conveniences such as online appointment scheduling and prescription refills and patient-provider email communication. The ongoing maturation of the millennial cohort, as well as further advancements in technology, will continue to influence the healthcare industry, including tenant location and building type preferences, through the long term.

HEALTHCARE REAL ESTATE TRENDS

The medical office market continued to tighten through mid-2014, when the vacancy rate dipped below 11% for the first time since the start of the recession. Tenant demand remains strong, particularly for high-quality, well-located product. In addition, construction activity has been decreasing the last few years amid uncertainty regarding the ACA's impact on the healthcare real estate market, as well as tight lending standards for most types of commercial real estate development. Relative to both CBD and suburban traditional office, medical office proved to be a tighter and more stable property type during the recession and recovery. Both the CBD and suburban traditional office vacancy rates peaked in H1 2010 at 15.0% and 16.9% respectively. Since then, the CBD vacancy rate has decreased by 248 basis points (bps) to 12.5%, and the suburban vacancy rate has decreased by 261 bps to 14.3% in H1 2014. By contrast, the medical office vacancy rate peaked at just 11.8% in H2 2009 and has been trending down gradually since then with a 97 bps decrease from the cyclical peak to its current level of 10.9%. Factors contributing to stability in the medical office space are long lease terms(typically 7-10 years), as well as the high cost and significant amount of time required to make the tenant and specialty-specific improvements to a medical office space. Such are factors often deter tenants from relocating.

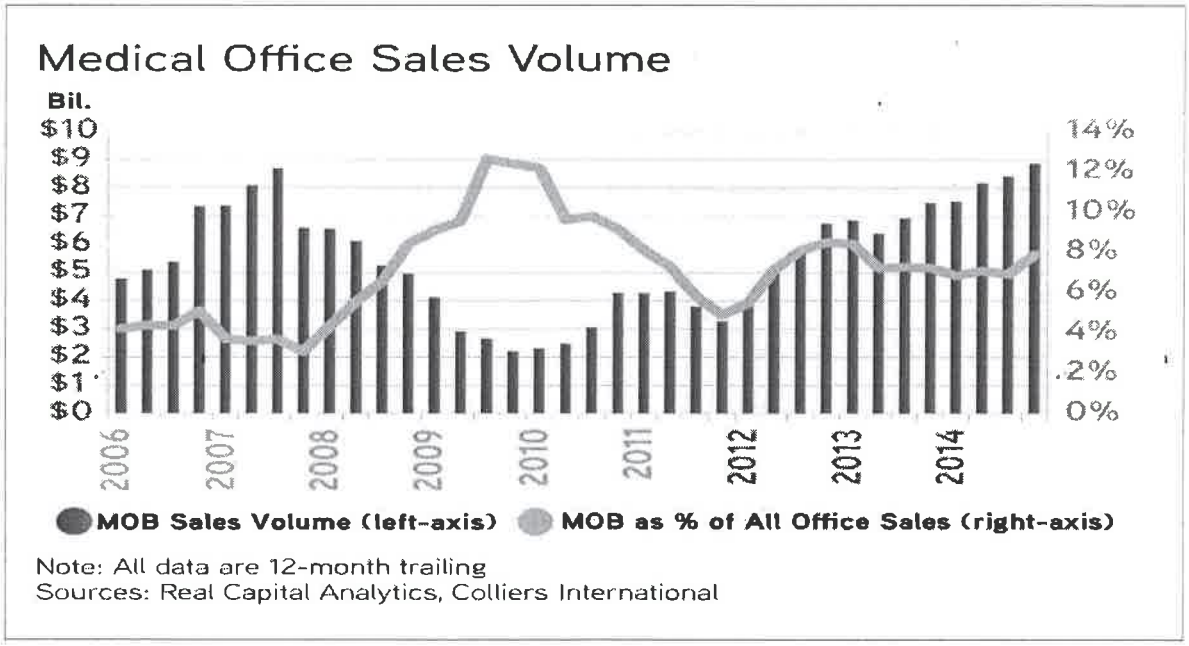
The medical office market also has exhibited consistency across regions. In H1 2014, the region with the highest vacancy rate (the Northeast at 11.3%) was separated from the region with the lowest vacancy rate (the South at 10.6%) by just 70 bps. Between 2009 and 1H 2014, the South, Midwest and West vacancy rates all remained between 10% and 13%, while the Northeast vacancy rate increased gradually from 8.6% in 1H 2009 to 11.3% in 1H 2014. By market, the lowest vacancy rates in H1 2014 generally were in small, Southeastern markets (e.g. Charleston, Greenville); markets with little or no construction activity during the last five years (e.g. Savannah, Miami); and markets with favorable economic and demographic

Source: Colliers International Medical Office Highlights 2015 Outlook

Trends (e.g. Boston, Seattle, Portland, OR). Likewise, many of the markets with the highest vacancy rates experienced a large amount of new supply coming to market in recent years (e.g. Chicago, Atlanta), or had deep recessions and/or slow economic recoveries (e.g. Las Vegas, Phoenix). However, markets such as Chicago and Atlanta are starting to absorb this excess inventory, resulting in larger vacancy rate decreases between 1H 2013 and 1H 2014 than the decrease in the overall U.S. vacancy rate during the same period.

Also representative of the stability in the MOB space are absorption trends in recent years. All of the regions posted positive absorption each year between 2009 and 2013, and the MOB market was on track to continue this trend in 2014 with more than 1.7 msf of positive absorption during the first half of the year. The booming Houston market, also home to the world's largest medical complex (Texas Medical Center), accounted for nearly one-quarter of absorption among the markets tracked by Colliers during H1 2014.

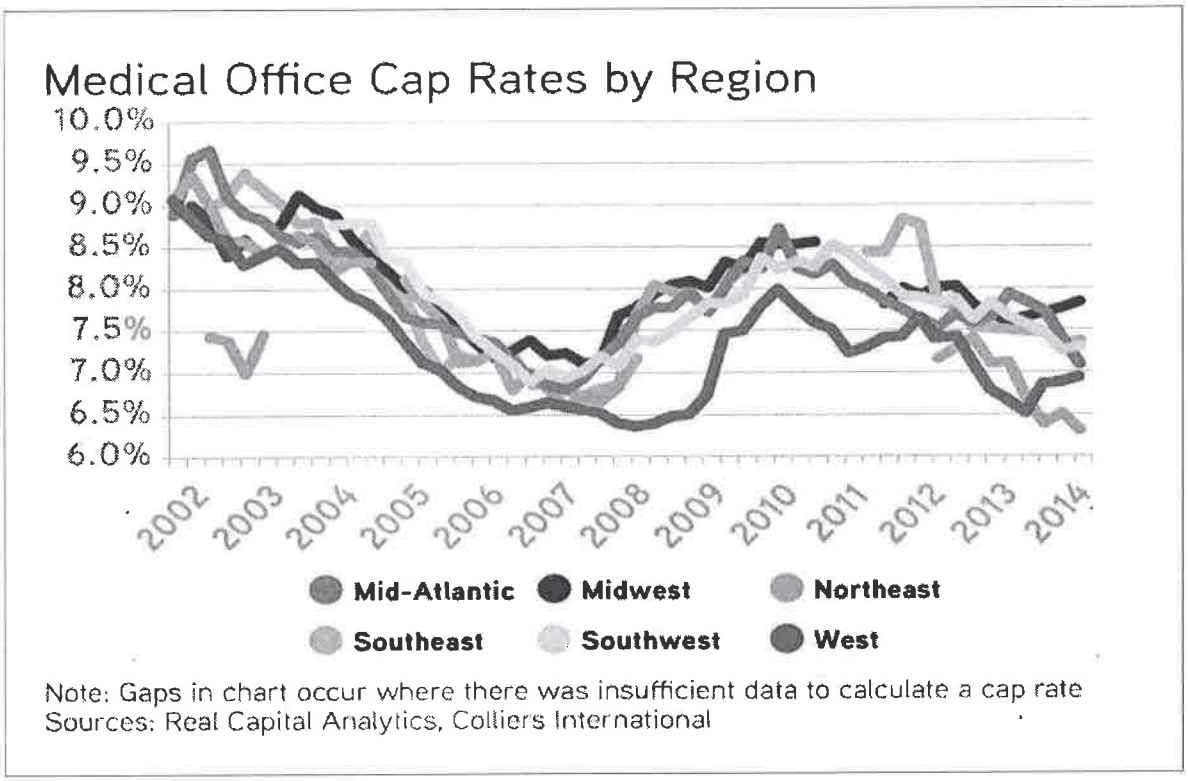
Despite uncertainty regarding the impact of the ACA on the healthcare industry and real estate market, medical office properties remain highly sought after by commercial real estate investors. The historical stability of the property type, coupled with favorable demographic trends, contributed to a smaller decline in transaction volume during the recession than the overall office market and a strong rebound in sales activity during the recovery. Also, low borrowing costs and a favorable capital-raising environment have been contributing to the flood of capital chasing healthcare properties with REITs in particular paying aggressive prices for top-tier assets. According to Real Capital Analytics (RCA), medical office sales transaction volume totaled $3.3 billion in Q4 2014, the highest quarterly total since Q4 2006. Total 12-month trailing transaction volume reached $8.9 billion in Q4 2014, exceeding the previous 12-month trailing peak of $8.7 billion in Q3 2007. In contrast, 12-month transaction volume in the overall office market reached $112.5 billion in Q4 2014, less than half the previous peak of $235.5 billion in Q3 2007.



Source: Colliers International Medical Office Highlights 2015 Outlook

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

The bifurcation trend occurring in the medical office leasing market is also prevalent in the investment market. The highest-quality, institutional-grade assets are the most heavily pursued by investors, trading at cap rates at or below record low levels. Even at current, very low interest rates, investors are paying virtually no risk premium for top-tier assets. According to RCA, the average cap rate for the top quartile of assets trading during 2014 was just 2.5%. Reflecting this voracious demand, some properties under construction are being acquired and even closing before they are completed.



REITs seeking high-quality properties dominated the MOB acquisition market in 2014, accounting for 46% of buyer volume during the year, which is up from just 16% in 2013. Ventas, Griffin-American Healthcare REIT III and Healthcare Trust of America ranked among the top four acquirers of healthcare properties in 2013 and 2014. CNL Healthcare Properties closed out 2014 with the acquisition of a nine-building portfolio of Class A buildings in the Southeast. The portfolio was 92% leased to leading medical systems such as Novant Health and Duke LifePoint Healthcare. Private buyers were the second-largest MOB capital source, accounting for 36% of sales volume in 2014. Unlike traditional office properties, the medical office investment universe is nearly entirely comprised of domestic buyers. Cross-border investors accounted for a mere 1% of sales volume in 2014 and just 2% of volume in each of the previous two years.

Source: Colliers International Medical Office Highlights 2015 Outlook

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

On the flip side, properties that are below institutional grade are seeing little demand from investors. The average cap rate for the bottom quartile of MOBs was nearly 11.5% in 2014, according to RCA. Heavy demand for high-quality assets is prompting development of new space rather than driving investors further out on the risk spectrum to lower-quality properties and less desirable locations. The sluggish recovery in the traditional office market also is contributing to weak demand for these properties. In past cycles, some of these properties would have been attractive targets for repurposing for traditional office use. In the current cycle, however, tenant demand and rent levels, particularly in the suburban office market, have been insufficient to justify repositioning these assets.

Capitalizing on aggressive demand and pricing for MOBs, many owner-occupier independent physicians, practices and hospitals are disposing of their assets. A desire among physicians to focus on their core competencies and the high cost of compliance with the ACA are other, secondary factors driving this trend. The current low cap rate environment is encouraging practitioners to complete sale-leaseback transactions that allow them to monetize their assets while securing low lease payments. Physician practices that desire to acquire their buildings are struggling to compete on pricing, yet faced with few attractive alternative investment options. This disposition trend is likely to continue as long as interest rates remain low and robust demand for healthcare real estate persists.

Based on the data as presented, we expect the MOB and healthcare real estate sector to remain strong for the foreseeable future. Demographic trends will support continuing demand for the next 25+ years, driving increasing health care employment. Some constriction on development remains due to uncertainty surrounding the ACA and other changes, but these should ease as clarity regarding these regulations emerges. The recovery of the general economy will likely add fuel to these trends as employment recovers and the insured population increases.

Positive economic and demographic trends will likely continue to attract investors to the sector. However, a gap will persist between well-located, modern investment-grade properties and older product less suited for current tenant needs and preferences. Overall, the near-term outlook remains strong, and medical office will likely continue to be a leading sector in the real estate market.

Source: Colliers International Medical Office Highlights 2015 Outlook

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

IDENTIFICATION OF THE PROPERTY

The Subject is a 5.59 +/- acre parcel that is proposed to be a vacant pad ready parcel. As of the date of inspection the subject was improved with a medical facility however it is our understanding that those improvements are to be razed. The subject is located in the medical district being near the Jackson-Madison County General Hospital as well as other large medical facilities. The subject has a physical address of 616 West Forest Avenue in Jackson, TN and is identified as parcels 1.00 and 39.00 in group J on map 66M in the Madison County Property Assessors Office. The present ownership to the property is recorded on page 1583 of deed book 696 in the Madison County Registers Office. The subject is located in a B-1(Medical and Related Services) Zoning District. We were provided a survey plat of the parcel which is included in the report.

PROPERTY INTEREST/HISTORY OF OWNERSHIP

Fee Simple, with West Tennessee Healthcare, Inc. being the current owner for the subject property. The subject property has been under the same ownership for more than three years.

PURPOSE OF THE APPRAISAL/PROPERTY RIGHTS APPRAISED

The purpose of the appraisal is estimate the annual market rent of the subject property fee simple interest. A fee simple estate is defined as: Absolute ownership unencumbered by any other interest or estate, subject only to the limitations imposed by the governmental powers of taxation, eminent domain, police power, and escheat.

INTENDED USE AND INTENDED USERS OF THE APPRAISAL

This report is to be used by West Tennessee Healthcare. It is our understanding that West Tennessee Healthcare is considering entering a ground lease on the subject property as vacant and this report was prepared to assist in that process.

EFFECTIVE DATE OF VALUATION AND DATE OF REPORT

The opinions expressed in this report are stated as of the effective valuation date of October 26, 2015 which is when the appraiser last made an inspection of the subject. The date of the report is October 30, 2015.

EXPOSURE TIME

It is our opinion that a fair estimate of exposure time for the subject property is one to two years with active marketing efforts. We have no data to support the estimate exposure time, however we feel it to be a reasonable timeframe.

EXTRAORDINARY ASSUMPTIONS AND HYPOTHETICAL CONDITIONS

This appraisal is based on the hypothetical condition of the subject property being a vacant pad ready parcel. The report does not make any other extraordinary assumptions or hypothetical conditions that would have a substantial impact on the subject property's value.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

DEFINITION OF MARKET RENT

Market Rent means the most probable price which a property should bring in a competitive and open market reflecting all conditions and restrictions of the specified lease agreement including term, rental adjustment and revaluation, permitted uses, use restrictions, and expense obligations, the lessee and lessor each acting prudently and knowledgeably, and assuming consummation of a lease contract as of a specified date and the passing of the leasehold from lessor to lessee under conditions whereby:

1. Lessee and Lessor are typically motivated;
2. Both parties are well informed or advised, and acting in what they consider their own bests interests;
3. A reasonable time is allowed for exposure in the open market;
4. The rent payment is made in terms of cash in U.S. dollars, and is expressed as an amount per time period consistent with the payment schedule of the lease contract; and
5. The rental amount represents the normal consideration for the property leased unaffected by special fees or concessions granted by anyone associated with the transaction.

THE SCOPE OF THE APPRAISAL

This report reflects a summary of our market data analysis, competitive properties, and our inspection of the subject property and valuation approaches employed. The scope of this appraisal report encompasses the research and analysis to prepare a report in accordance with the intended use and the Uniform Standards of Professional Appraisal Practice of the Appraisal Foundation. The basis of this report consists of the collection, confirmation, and analysis of data to derive an opinion of market value of the subject property. Public records and private data sources were researched to identify neighborhood trends, land sales, sales of comparative properties and an overview of the market found within the subject's respective neighborhood. Analysis of the data gathered in our research was incorporated into the appropriate methods utilized in this report to derive an estimate of the subject property's value. The scope of work involved the following steps.

1. We completed an inspection of the Subject property and took photographs on October 26, 2015. We were not accompanied by anyone during our inspection nor did we inspect the interior of any existing improvements on the property.
2. Regional, city and county, and neighborhood data was based on information available at and provided by the Jackson-Madison County Chamber of Commerce, Tennessee Department of Economic and Community Development, and personnel with the local government agencies. Neighborhood data was also developed based on a physical inspection of the area by the appraiser.
3. The Subject property data was developed from information provided by the client, from public records found at the appropriate Courthouse, and from a physical inspection of the property by the appraiser.
4. In estimating the highest and best use of the subject property, an analysis was made based on the data compiled in the steps above.
5. In developing the approaches to value, the market data used was collected from David Horton & Associates, Inc. office files, other appraisers, public records, and others knowledge of the subject property marketplace.
6. After collecting and analyzing the data, a final estimate of value was developed from the correlation of the appropriate approaches to value.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

SITE DESCRIPTION

LOCATION/ZONING

The Subject has a physical address of 616 West Forest Avenue in Jackson, TN and is located in a medically oriented area near the street from the Jackson-Madison County General Hospital. The subject is situated at the corners of West Forest Avenue and Forest Cove and West Forest Avenue and Linda Vista Drive. The subject enjoys good visibility and access from all three streets. The subject area has seen steady development over recent years with some of the largest projects being the construction of West Tennessee Healthcare Medical Center Physicians Tower and the Kirkland Cancer Center. The Medical Center Physicians Tower is a multi-story medical office building consisting of 107,000+/- square feet while the Kirkland Cancer Center is a multi-story medical office building consisting of 82,000 +/- square feet. Both properties are located just west of the subject. Property values and occupancy levels in the subject area appear to be relatively stable.

We have spoken to personnel with the city government and were informed that the subject is situated in a B-1 (Medical and Related Services) Zoning District. We have included a copy of the zoning guidelines in the addendum section of this report.

DIMENSIONS AND TOPOGRAPHY

The subject site includes 5.59 +/- acres. The subject site is irregular in shape but includes approximately 607' +/- of frontage on West Forest Avenue, 423' +/- of frontage on Forest Cove, and 271' of frontage on Linda Vista Drive. Being situated at two corners gives the subject parcel good visibility and access. The subject is currently improved with a building and site improvements however per the request of our client this report is based on the hypothetical condition of the subject being a vacant pad ready parcel. A majority of the parcel is generally level and the acreage does not appear to be located in a FEMA Flood Hazard Area according to the map we have included in the addendum section of this report.

PUBLIC IMPROVEMENTS

West Forest Avenue is a four lane city street that runs east to west from North Highland Avenue to Hollywood Drive. Forest Cove is a two lane dead-end street that runs south from West Forest. Linda Vista is a two lane mostly residential street running south off of West Forest. There is a public sidewalk running along the subject's frontage on West Forest Avenue. It is our understanding that public utilities to the subject include electricity, water, natural gas, sewer, and telephone.

EASEMENTS / ENCROACHMENTS

There are no known easements or encroachments on the subject property which significantly affect the property value. Typical utility easements are assumed to be included with the property however they are common in the subject's market area.

SUMMARY

The subject is located in the main medical area of the city being near the Jackson Madison County General Hospital where property values appear to be stable. The subject is a corner lot which gives the property good access and visibility. The subject's setting makes it desirable for medical use development.

SUPPLEMENTAL #2

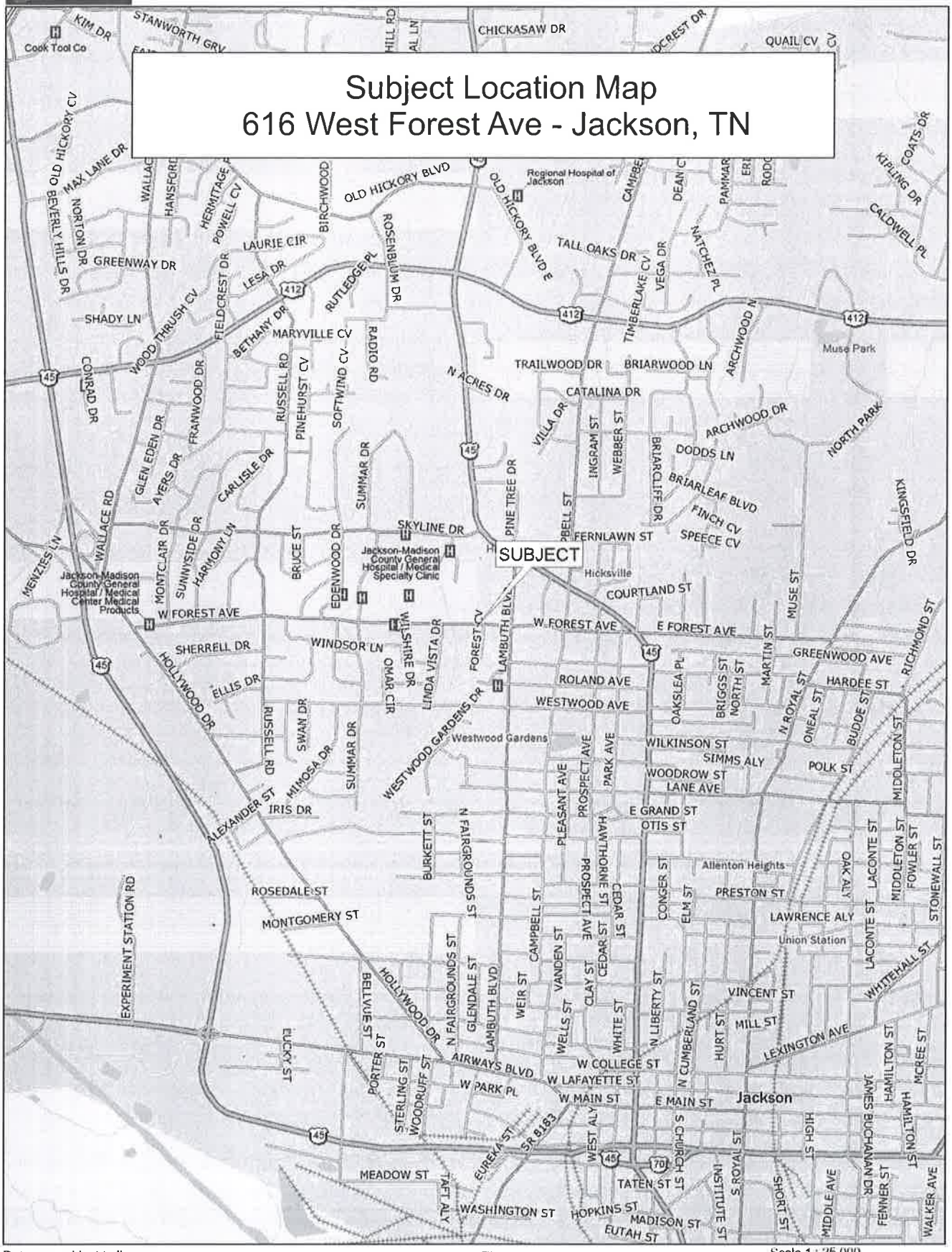
November 12, 2015

11:52 am

DeLorme

DeLorme Street Atlas USA® 2014

Subject Location Map
616 West Forest Ave - Jackson, TN



Data use subject to license.

© DeLorme. DeLorme Street Atlas USA® 2014.

www.delorme.com

TN

MN (2.1°W)

Scale 1 : 25,000

0 600 1200 1800 2400 3000 ft

0 200 400 600 800 1000 m

1" = 2,083.3 ft

Data Zoom 13-0

PART IV. VALUATION, ANALYSIS AND CONCLUSIONS

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

HIGHEST AND BEST USE

Highest and best Use is defined as follows:

> The reasonably probable and legal use of vacant land or an improved property, which is physically possible, appropriately supported, financially feasible, and that results in the highest value.

Consideration has been given to the four criteria used to determine *Highest and Best Use.* These criteria are as follows and the use must be:

- Physically possible
- Legally permissible
- Financially feasible, and
- Maximally productive (returns the highest net land value)

The highest and best use analysis results in the most probable and reasonable highest present value of the property as of the effective date of appraisal. When the land is substantially developed with improvements meeting the above criteria, it is unlikely that redevelopment would occur in the foreseeable future or during the remaining economic life of the improvements. This analysis is performed under a use premise of general commercial purposes.

ANALYSIS AND CONCLUSION

The land value as estimated herein was based on the highest and best use as if the site were vacant. Considering the four criteria above, the conclusion of the highest and best use of the site if vacant is the development for medical use purposes. In the case of this property, we are satisfied that there is no better and more profitable use.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

THE APPRAISAL PROCESS

The appraisal process is an orderly analytical procedure wherein data is acquired, classified, analyzed and then processed into a value indication by various appraisal techniques. The three approaches applied are the Cost Approach, the Sales Comparison Approach, and the Income Capitalization Approach. These represent the three alternatives available to an investor.

Each approach has its strengths and weaknesses, depending on the type of property being appraised and the quality of data available. In most instances, one or more of these approaches will produce a more reliable value indication than the other approach, or approaches. Therefore, the final step in the appraisal process is the Reconciliation of all the value indications into the formulation of a final opinion of value. This step usually begins with a discussion of the merits of each approach and an analysis of the reliability of the data used in each. It concludes with a statement of the final opinion of value.

COST APPROACH

This approach to value is based on the assumption an informed purchaser would pay no more than the cost of producing a substitute property with the same utility as that of the subject property assuming no undue delay to construction. Considering the request for this appraisal was for an opinion of annual market rent for the subject property as a vacant parcel. This approach is not considered applicable in the scope of this assignment.

SALES COMPARISON APPROACH

The Sales Comparison Approach is based on the proposition that an informed buyer would pay no more for a property than the cost to acquire an existing one with the same utility. This approach is a method of estimating the market value of a property by comparing it to similar properties that have recently sold. We have applied this approach to arrive at a market value and then considered the annual market rent for the subject property based on its market value.

INCOME CAPITALIZATION APPROACH

The Income Capitalization Approach is based on the principle of anticipation which states that value is created by the expectation of benefits to be derived in the future. The request for this appraisal was for an opinion of annual market rent for the subject property as a vacant parcel. This approach is not considered applicable in the scope of this assignment.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

SALES COMPARISON APPROACH TO VALUE

The Sales Comparison Approach is used to estimate the value of the subject property by comparing it to recently sold properties. This approach to value is applicable when recent sales of comparable properties are available. The Sales Comparison Approach to value is based on the proposition that an informed buyer would pay no more for a property than the cost to acquire another property of similar utility.

Comparable sales are chosen on the basis of their similarity to subject property; the more similar a comparable is the more reliable it is considered. Since few properties are exactly alike, adjustments for dissimilarities must be considered. If sufficient information is available, adjustments are made in terms of dollars and typically take into consideration the rights conveyed, financing terms, conditions of sale, date of sale, location, and physical characteristics of the properties. In some cases when sufficient information is not available, adjustments involve the appraiser's judgment and understanding of the subject's market area. Major consideration is usually given to the comparable having the least total adjustment and dissimilarities.

The most common unit of comparison for this type of property is price per acre. This unit of comparison is used to compare the subject as unimproved to the comparable sales listed.

The estimate of value derived from this Approach indicates what the subject property should sell for if exposed a reasonable length of time in the marketplace. Unless otherwise listed and described, we gained our resource data from the selling agent, buyer, seller, lender, owner, closing attorney, public records, realtor data, buying agent or a combination of the above. We make no guarantees, but believe the data obtained and used to be correct and accurate.

After arriving at an opinion of the market value of the subject parcel, we have then considered its annual market rent. We have reviewed local and national data and arrived at a market indicated percentage of what the annual market rent would be of the property's market value. This is farther explained on following pages.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

UNIMPROVED COMPARABLE SALE #1

Property Identification

Property Type:	"As if" Vacant Parcel
Property Address:	1301 North Highland Ave. – Jackson, TN
Deed Book/Page:	721/172
Tax Assessors ID:	65P – G – 25.00

Land Information

Area:	1.29 +/- Acres
Zoning:	B-4, General Business District
Shape:	Irregular
Topography:	Slightly Rolling
Utilities:	Similar to Subject

Sales Information

Seller:	Wesley Wolf ETAL
Buyer:	Family Dollar Stores of TN Inc.
Verification:	Assessor, Warranty Deed
Property Rights:	Fee Simple
Conditions of Sale:	Typical Transaction
Financing:	Cash to seller
Date of Sale:	October 10, 2013
Sales Price:	$395,000.00
Sales Price per Square Foot:	$306,202.00

Remarks

This property is located in the same general area as the subject but fronts on North Highland Avenue which is a main thoroughfare thru the city of Jackson. The property was previously improved however the improvements were razed. The site has been improved with a retail building since the sale.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

UNIMPROVED COMPARABLE SALE #2

Property Identification

Property Type:	Vacant Parcel
Property Address:	Union University Drive – Jackson, TN
Deed Book/Page:	724/256
Tax Assessors ID:	44 – 50.20, 50.21, 50.24

Land Information

Area:	5.11 +/- Acres
Zoning:	SC-1, Planned Unit Commercial Development
Shape:	Mostly Rectangular
Topography:	Mostly Flat
Utilities:	Similar to Subject

Sales Information

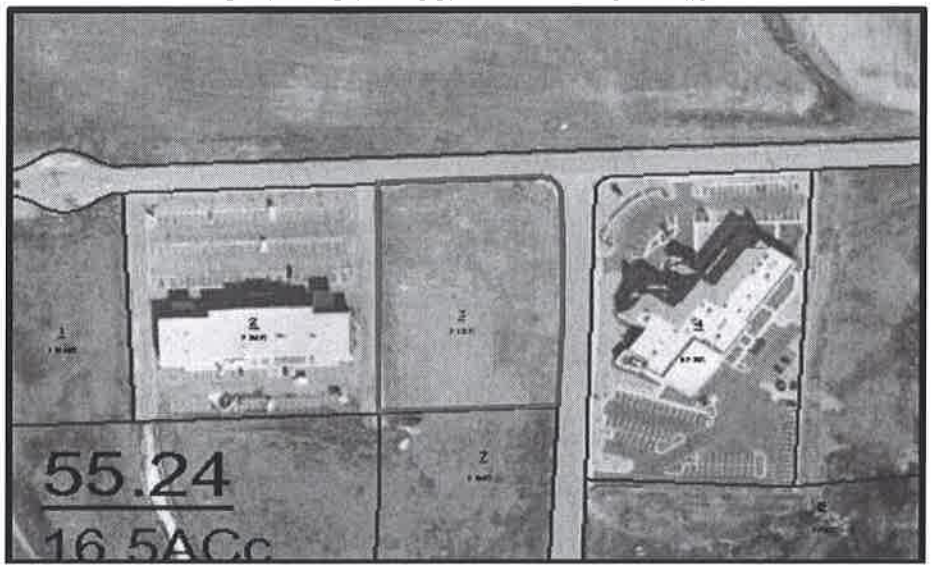
Seller:	Thomsen Farms LLC
Buyer:	Robert Reynolds
Verification:	Assessor, Warranty Deed
Property Rights:	Fee Simple
Conditions of Sale:	Typical Transaction
Financing:	Cash to seller
Date of Sale:	May 21, 2014
Sales Price:	$1,335,354.00
Sales Price per Acre:	$261,322.00

Remarks

This property is located in the northern part of the city and is part of a new development that has seen a moderate rate of development. The topography of the subject parcel is mostly flat and appears to have adequate drainage. A 0.53 acre parcel has been sold off of the acreage since this sale. The remainder of the parcel remains vacant as of this report.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

UNIMPROVED COMPARABLE SALE #3



Property Identification

Property Type:	Vacant Parcel
Property Address:	201 Sterling Farms Dr – Jackson, TN
Deed Book/Page:	724/725
Tax Assessors ID:	33O – B – 3.00

Land Information

Area:	2.61 +/- Acres
Zoning:	SC-1 Planned Unit Commercial Developent
Shape:	Rectangular
Topography:	Mostly Flat
Utilities:	Similar to Subject

Sales Information

Seller:	C&L Properties LLC
Buyer:	Tennessee Farmers Life Insurance Co.
Verification:	Assessor, Warranty Deed
Property Rights:	Fee Simple
Conditions of Sale:	Typical Transaction
Financing:	Cash to seller
Date of Sale:	June 5, 2014
Sales Price:	$565,000.00
Sales Price per Square Foot:	$216,475.00

Remarks

This property is located in the same city as the subject and appears to be in a comparable setting to the subject. The topography of the parcel is mostly flat open ground that appears to have adequate drainage. The parcel remains vacant as of this report.

SUPPLEMENTAL #2
November 12, 2015
11:52 am

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

UNIMPROVED COMPARABLE SALE #4

Property Identification

Property Type:	Vacant Parcel
Property Address:	11 Creek Stone Cove – Jackson, TN
Deed Book/Page:	717/746
Tax Assessors ID:	33O – B – 7.00

Land Information

Area:	1.85 +/- Acres
Zoning:	SC-1 Planned Unit Commercial Developent
Shape:	Rectangular
Topography:	Mostly Flat
Utilities:	Similar to Subject

Sales Information

Seller:	Realty Investors Group LLC
Buyer:	Keith Taylor
Verification:	Assessor, Warranty Deed
Property Rights:	Fee Simple
Conditions of Sale:	Typical Transaction
Financing:	Cash to seller
Date of Sale:	January 25, 2013
Sales Price:	$322,788.00
Sales Price per Square Foot:	$174,480.00

Remarks

This property is located in the same city as the subject and appears to be in a comparable setting. The topography of the parcel is mostly flat open ground that appears to have adequate drainage. The parcel remains vacant as of this report.

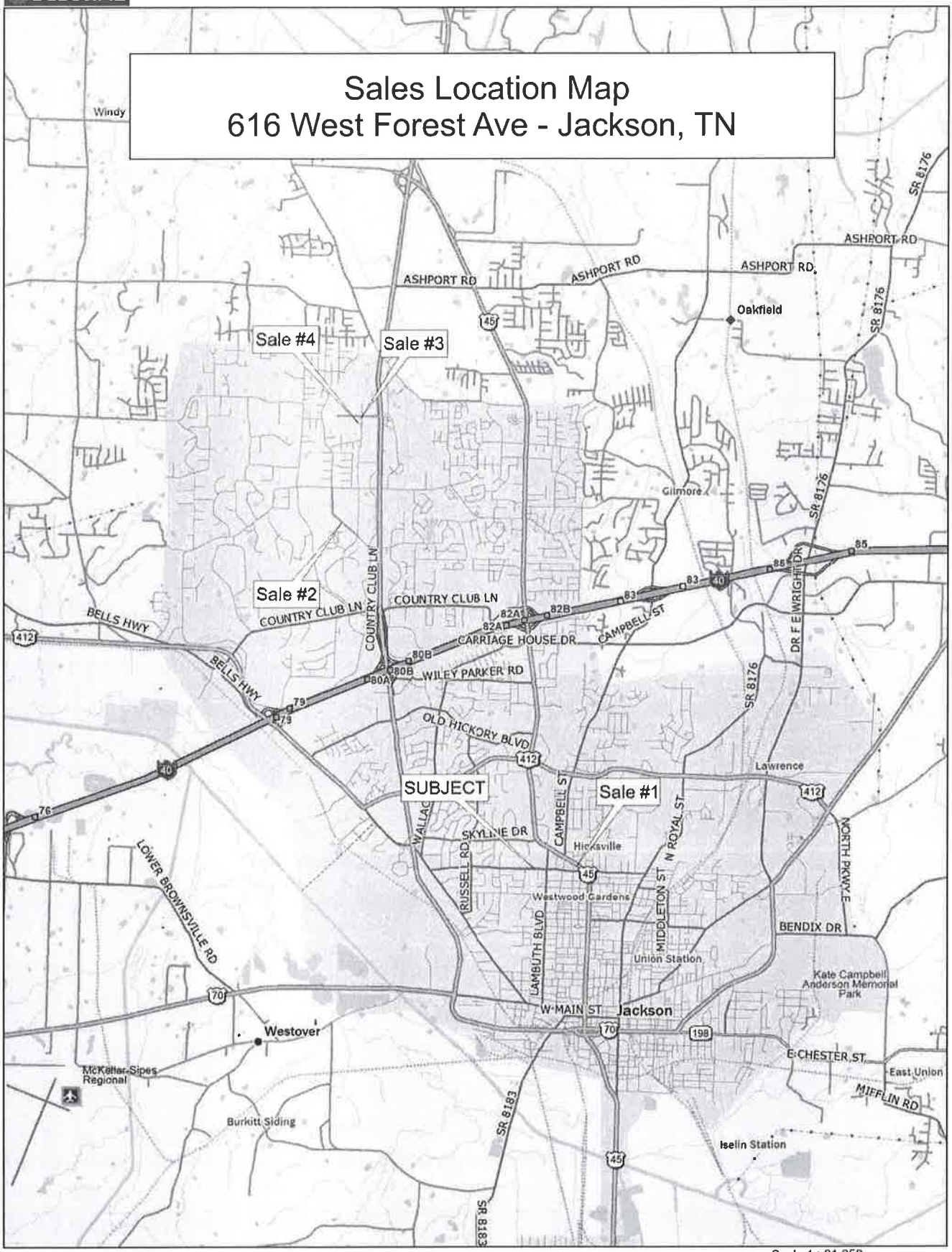
SUPPLEMENTAL #2

November 12, 2015

11:52 am

DeLorme Street Atlas USA® 2014

Sales Location Map
616 West Forest Ave - Jackson, TN



Data use subject to license.

© DeLorme. DeLorme Street Atlas USA® 2014.

www.delorme.com

TN

MN (2.1°W)

Scale 1 : 81,250

1" = 1.28 mi

Data Zoom 11-3

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

LAND SALES ADJUSTMENT GRID

	Subject	Sale 1	Sale 2	Sale 3	Sale 4
Address	616 West Forest Ave Jackson, TN	1301 N Highland Ave Jackson, TN	Union University Dr Jackson, TN	201 Sterling Farms Dr Jackson, TN	11 Creek Stone Cv Jackson, TN
Sales Price		$395,000	$1,335,354	$565,000	$322,788
Acres		1.29 +/-	5.11 +/-	2.61+/-	1.85/-
Price per Acre		$306,202	$261,322	$216,475	$174,480
Adjustments					
Property Rights Conveyed		Fee Simple	Fee Simple	Fee Simple	Fee Simple
Terms of Sale		Cash to Seller	Cash to Seller	Cash to Seller	Cash to Seller
Conditions of Sale		Arms-length	Arms-length	Arms-length	Arms-length
Date of Sale		10/10/2013 +4%	5/21/2014 +2%	6/5/2014 +2%	1/25/2013 +4%
Adjusted Price per Acre		$318,450	$266,548	$220,804	$181,459
Size	5.59 +/-	Smaller -10%	Similar -0-	Smaller -10%	Smaller -10%
Shape/Topography	Good	Inferior +10%	Similar -0-	Similar -0-	Similar -0-
Frontage/Situated	Good	Inferior +10%	Inferior +10%	Similar -0-	Inferior +10%
Location/Visibility	Average	Superior -20%	Superior -10%	Inferior +10%	Inferior +10%
Highest and Best Use	Medical Oriented Development	Superior -20%	Superior -20%	Similar -0-	Similar -0-
Indicated Value per Acre		$222,915	$213,238	$220,804	$199,605

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

SUMMARY OF VALUE

Based on the land sale comparables and analysis, the subject land value is estimated to be $215,000.00 per acre. Summary as follows:

Indicated Value	
Value Per Acre	$215,000
Subject Acres	5.59 +/-
Total	$1,201,850
Rounded	$1,202,000

INDICATED VALUE FROM SALES COMPARISON APPROACH

$1,202,000.00

SUPPLEMENTAL #2
November 12, 2015
11:52 am

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

ANNUAL MARKET RENT OPINION

The purpose of this report is to render an opinion of annual market rent for the subject property. West Tennessee Healthcare is considering an offer to lease the subject property under a long term agreement for the purpose of improving with a medical facility. The subject includes a 5.59 +/- acre parcel that is pad ready and suitable for improvements. The cost to improve the property would be born solely by the lessee.

BASE RENT

The appraisers have been asked to provide an opinion of annual market rent which has been defined on previous pages of the report. The annual market rent or base rent is an annual amount guaranteed to the lessor. To estimate the annual market rent or ground lease rate for the subject property, we have researched the market for comparable properties that are currently being leased. We have found that these type lease comparables are not common in the subject area and when similar properties are leased the details of the agreement are not typically made available. Due to the limited land lease information available in the subject area, we have based our opinion of the subject's annual market rent as a percentage of its present market value. We have researched recent listings of vacant parcels and spoken to area real estate professionals in estimating a desired rate of return for properties similar to the subject. This research and conversations would indicate a rate of return for the subject property to be between 6-10%.

Additionally, we surveyed capitalization rates from national survey data. One source referenced was the most recently published 4 quarters of *RealtyRates.com, Investor Surveys* compiled by Robert G. Watts & Associates and RealtyRates.com. Below we have included charts that give an indication of market capitalization rates for land leases.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

RealtyRates.com INVESTOR SURVEY - 3rd Quarter 2015* LAND LEASES						
	Capitalization Rates			Discount Rates		
Property Type	Min.	Max.	Avg.	Min.	Max.	Avg.
Apartments	2.29%	10.50%	6.27%	4.89%	11.00%	7.27%
Golf	2.79%	15.70%	8.59%	5.39%	16.20%	9.59%
Health Care/Senior Housing	2.79%	11.87%	6.79%	5.39%	12.37%	7.79%
Industrial	2.65%	10.50%	6.40%	5.25%	11.00%	7.40%
Lodging	2.79%	15.46%	7.10%	5.39%	15.96%	8.10%
Mobile Home/RV Park	2.59%	12.42%	7.37%	5.19%	12.92%	8.37%
Office	2.42%	10.50%	6.76%	5.02%	11.00%	7.76%
Restaurant	3.90%	15.72%	8.14%	6.50%	16.22%	9.14%
Retail	2.35%	11.87%	6.52%	4.95%	12.37%	7.52%
Self-Storage	2.65%	10.50%	7.49%	5.25%	11.00%	8.49%
Special Purpose	2.79%	16.20%	8.24%	6.22%	18.26%	9.17%
All Properties	2.29%	16.20%	7.24%	4.89%	16.22%	8.14%

*2nd Quarter 2015 Data

RealtyRates.com INVESTOR SURVEY - 2nd Quarter 2015* LAND LEASES						
	Capitalization Rates			Discount Rates		
Property Type	Min.	Max.	Avg.	Min.	Max.	Avg.
Apartments	2.04%	10.38%	6.07%	4.64%	10.88%	7.07%
Golf	2.57%	15.48%	8.30%	5.17%	15.98%	9.30%
Health Care/Senior Housing	2.57%	11.75%	6.55%	5.17%	12.25%	7.55%
Industrial	2.43%	10.38%	6.17%	5.03%	10.88%	7.17%
Lodging	2.57%	15.24%	6.87%	5.17%	15.74%	7.87%
Mobile Home/RV Park	2.37%	12.20%	7.13%	4.97%	12.70%	8.13%
Office	2.23%	10.38%	6.61%	4.83%	10.88%	7.61%
Restaurant	3.52%	15.50%	7.87%	6.12%	16.00%	8.87%
Retail	2.13%	11.75%	6.29%	4.73%	12.25%	7.29%
Self-Storage	2.43%	10.38%	7.29%	5.03%	10.88%	8.29%
Special Purpose	2.57%	15.98%	7.96%	6.05%	18.08%	8.99%
All Properties	2.04%	15.98%	7.01%	4.64%	16.00%	7.91%

*1st Quarter 2015 Data

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

RealtyRates.com INVESTOR SURVEY - 1st Quarter 2015* LAND LEASES						
	Capitalization Rates			Discount Rates		
Property Type	Min.	Max.	Avg.	Min.	Max.	Avg.
Apartments	2.23%	10.38%	6.37%	4.83%	10.88%	7.37%
Golf	2.92%	15.83%	8.64%	5.52%	16.33%	9.64%
Health Care/Senior Housing	2.92%	11.75%	6.87%	5.52%	12.25%	7.87%
Industrial	2.78%	10.38%	6.50%	5.38%	10.88%	7.50%
Lodging	2.92%	15.59%	7.24%	5.52%	16.09%	8.24%
Mobile Home/RV Park	2.72%	12.55%	7.49%	5.32%	13.05%	8.49%
Office	2.78%	10.38%	6.88%	5.38%	10.88%	7.88%
Restaurant	3.43%	15.85%	8.14%	6.03%	16.35%	9.14%
Retail	2.48%	11.75%	6.64%	5.08%	12.25%	7.64%
Self-Storage	2.78%	10.38%	7.60%	5.38%	10.88%	8.60%
Special Purpose	2.92%	16.33%	8.24%	6.18%	18.36%	9.19%
All Properties	2.23%	16.33%	7.33%	4.83%	16.35%	8.24%

*4th Quarter 2014 Data

RealtyRates.com INVESTOR SURVEY - 4th Quarter 2014* LAND LEASES						
	Capitalization Rates			Discount Rates		
Property Type	Min.	Max.	Avg.	Min.	Max.	Avg.
Apartments	2.48%	10.36%	6.50%	5.08%	10.86%	7.50%
Golf	3.01%	15.92%	8.71%	5.61%	16.42%	9.71%
Health Care/Senior Housing	3.01%	11.73%	6.95%	5.61%	12.23%	7.95%
Industrial	2.79%	10.36%	6.62%	5.39%	10.86%	7.62%
Lodging	3.01%	15.68%	7.30%	5.61%	16.18%	8.30%
Mobile Home/RV Park	2.79%	12.64%	7.57%	5.39%	13.14%	8.57%
Office	2.79%	10.36%	6.88%	5.39%	10.86%	7.88%
Restaurant	3.79%	15.94%	8.22%	6.39%	16.44%	9.22%
Retail	2.57%	11.73%	6.75%	5.17%	12.23%	7.75%
Self-Storage	2.87%	10.38%	7.71%	5.47%	10.88%	8.71%
Special Purpose	3.01%	16.42%	8.32%	6.35%	18.43%	9.32%
All Properties	2.48%	16.42%	7.41%	5.08%	16.44%	8.32%

*3rd Quarter 2014 Data

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

SUMMARY OF MARKET RENT

We have considered the above to arrive a capitalization rate/rate of return of 7.5% for the subject property. This rate of return has been applied to the present market value of the subject property to arrive at an indicated market rent. This opinion is effective as of the date of inspection and does not consider any rent escalators or what the market rent would be in the future. Summary as Follows:

Summary of Annual Market Rent for Subject Site

Present Market Value of Subject Property:	$1,202,000.00
Capitalization Rate/Rate of Return	X 7.5%
Annual Market Rent of Subject Property	$ 90,150.00
Rounded:	$ 90,200.00

Summary of Annual Market Rent for Subject Area

$90,200.00

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

PART V. ADDENDUM

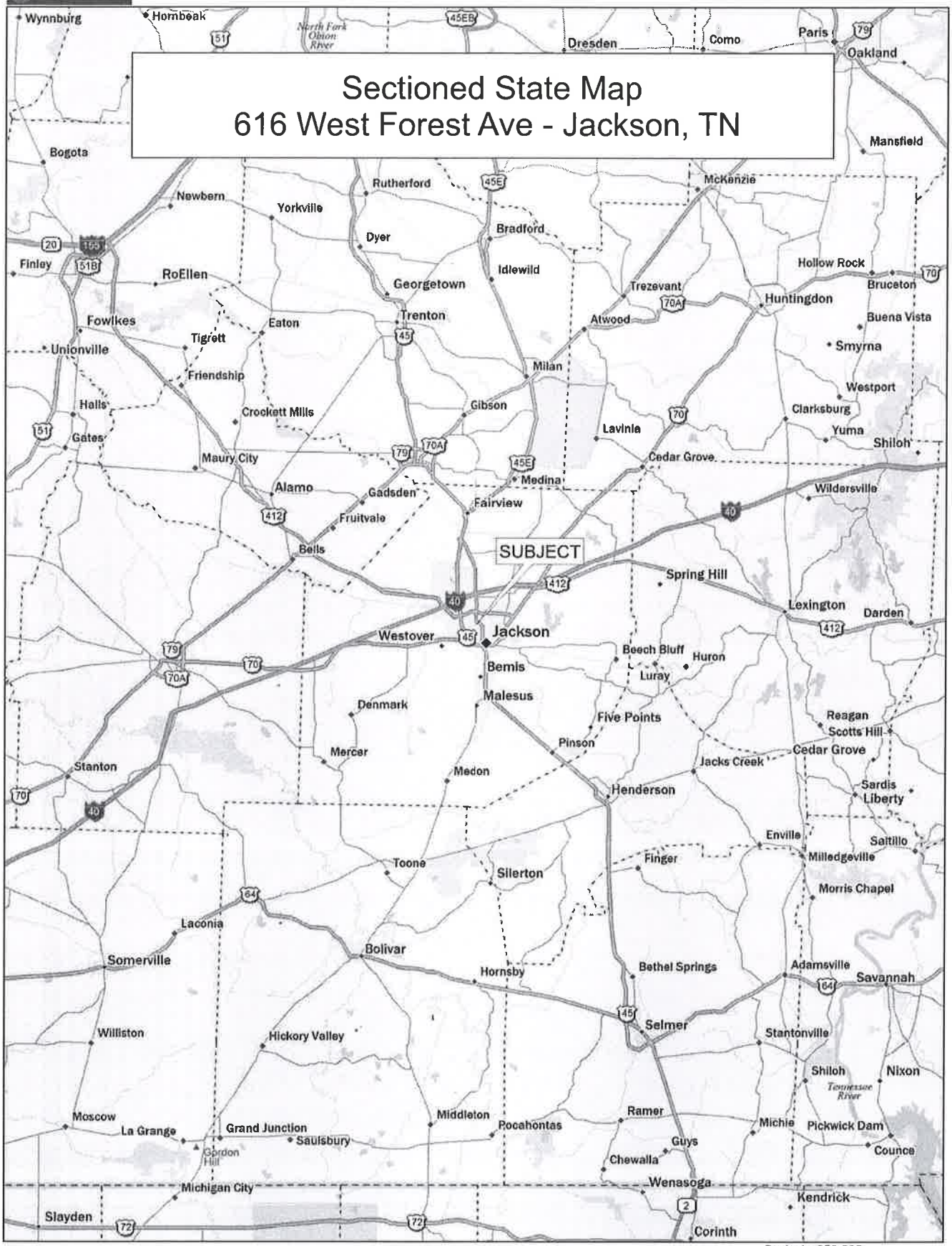
SUPPLEMENTAL #2

November 12, 2015

11:52 am

DeLorme Street Atlas USA® 2014

Sectioned State Map
616 West Forest Ave - Jackson, TN



TN

MN (2.1°W)

Scale 1 : 650,000

1" = 10.26 mi

Data Zoom 8-3

SUPPLEMENTAL #2

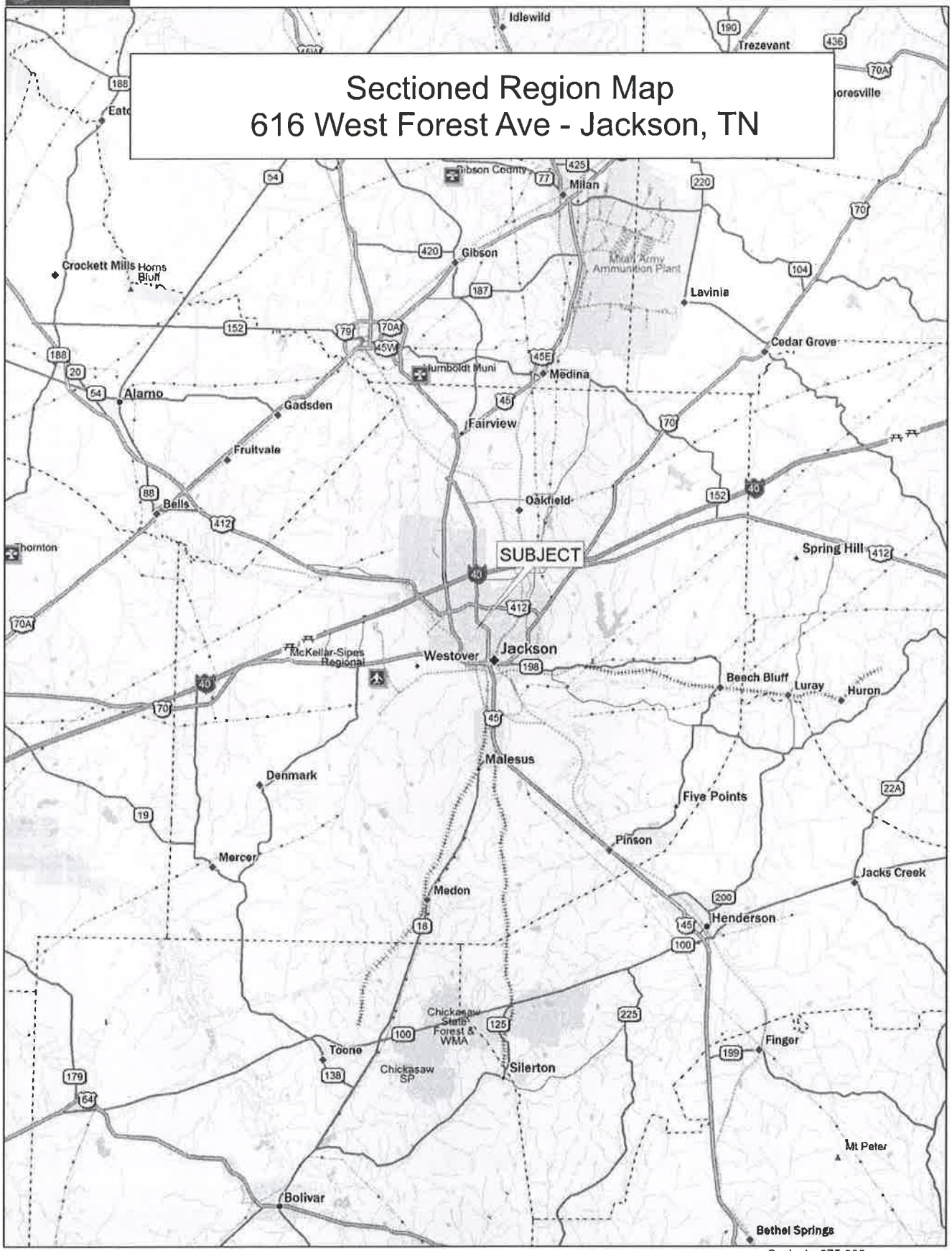
November 12, 2015

11:52 am

DeLORME

DeLorme Street Atlas USA® 2014

Sectioned Region Map
616 West Forest Ave - Jackson, TN



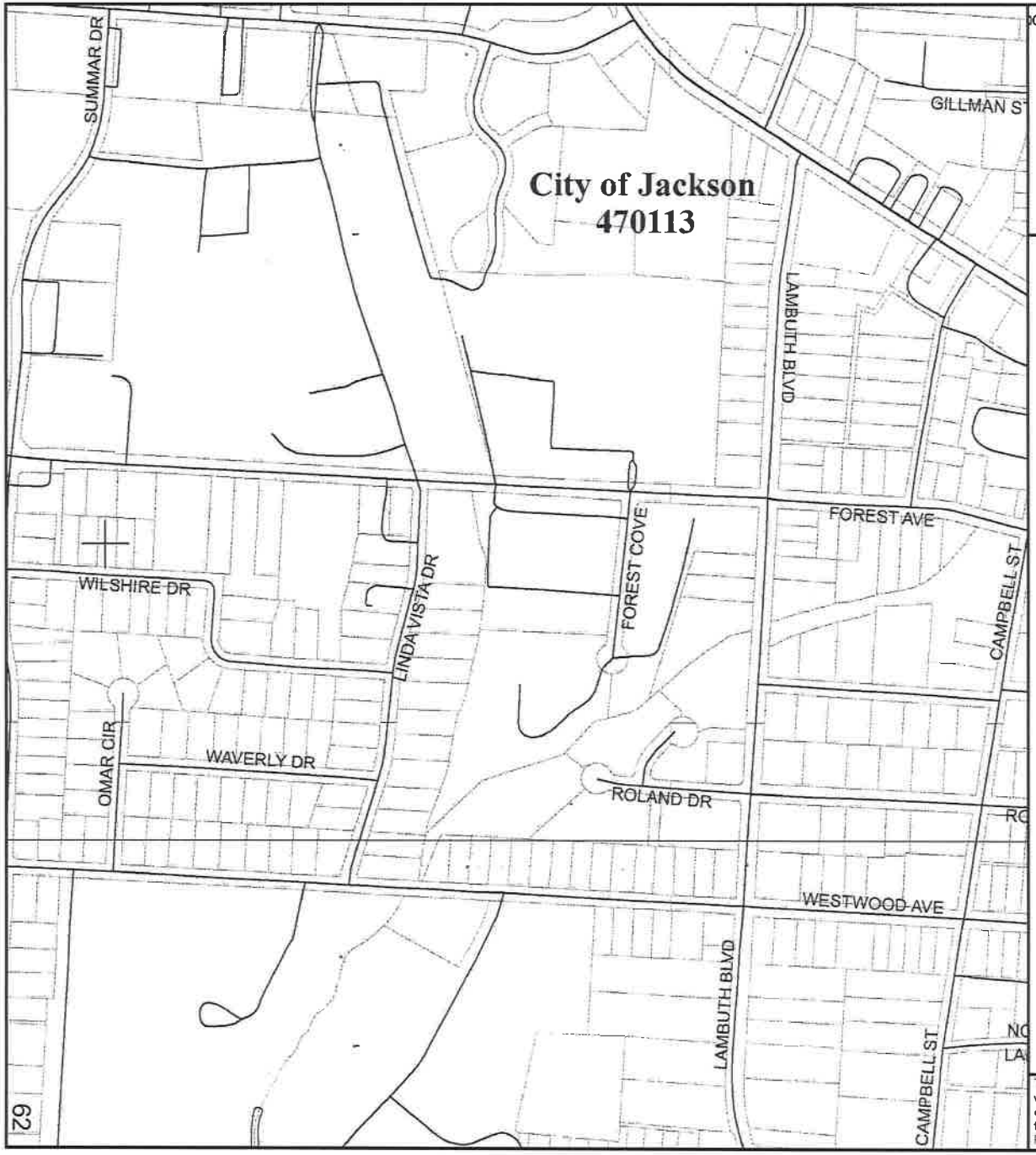
TN

MN (2.1°W)

Scale 1 : 375,000

1" = 5.92 mi

Data Zoom 9-1



d Insurance Program at 1-800-638-6620.

MAP SCALE 1" = 500'

250 0 250 500 750 1,000 FEET

NFIP

NATIONAL FLOOD INSURANCE PROGRAM

PANEL 0164E

FIRM

FLOOD INSURANCE RATE MAP

MADISON COUNTY, TENNESSEE

AND INCORPORATED AREAS

PANEL 164 OF 435

(SEE MAP INDEX FOR FIRM PANEL LAYOUT)

CONTAINS:

COMMUNITY	NUMBER	PANEL	SUFFIX
JACKSON, CITY OF	470113	0164	E

Notice to User: The Map Number shown below should be used when placing map orders; the Community Number shown above should be used on insurance applications for the subject community.

MAP NUMBER
47113C0164E

MAP REVISED
AUGUST 3, 2009

Federal Emergency Management Agency

This is an official copy of a portion of the above referenced flood map. It was extracted using F-MIT On-Line. This map does not reflect changes or amendments which may have been made subsequent to the date on the title block. For the latest product information about National Flood Insurance Program flood maps check the FEMA Flood Map Store at www.msc.fema.gov

SUPPLEMENTAL #2
November 12, 2015
11:52 am

SUPPLEMENTAL #2
November 12, 2015
11:52 am

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

TAX INFORMATION
(Estimated Considering Subject as Vacant Parcel)

PROPERTY OWNER:	West Tennessee Healthcare
LOCATION:	616 West Forest Avenue Jackson, TN 38301
TAX MAP:	66M – J – 1.00, 39.00
AREA/SIZE:	5.59 +/- Acres
IMPROVEMENTS:	None as Proposed

TAX APPRAISAL

LAND:	$835,000.00
IMPROVEMENTS:	$ 0
TOTAL:	$835,000.00
ASSESSED VALUE:	$334,000.00

CURRENT TAXES

COUNTY:	$6,579.80
CITY:	$7,181.00
TOTAL:	$13,760.80

LAND CLASSIFICATION

B1 - Medical and Related Services District

*Revised: 12/3/96
**Approved 8/4/09

SECTION 8
B-1 MEDICAL AND RELATED SERVICES DISTRICT

A. GENERAL DESCRIPTION

This district is intended primarily to provide a centralized location for major medical and related services to protect medical and related facilities in the area from adverse influences, and to promote the establishment of complementary facilities.

B. USES PERMITTED

Property and buildings in a B-1 Medical and Related Services District shall be used only for the following purposes:

1. Hospitals, clinics, and medical and dental offices.

*2.Nursing homes, homes for the aged, and assisted living facilities.

3. Laboratories and establishments for the production of eye-glasses, hearing aids and prosthetic appliances.

4. Drug store.

5. Barber shop and beauty shop.

6. Florist.

7. Accessory buildings and uses customarily incidental to the above uses.

8. Signs as regulated in Title 14 of the Official Code of the City of Jackson.

9. Therapeutic and health services.

10. Financial institutions, limited to the services of a full-service bank and/or a savings and loan association.

11. Motor inns.

12. Restaurants (excluding drive-inn facilities), provided that such facilities are incidental to other uses within a building.

*Revised: 2/7/95

13. Standard restaurant (excluding carry-out restaurants, fast food restaurants, and drive-inn restaurants).

14. Grocery store.

*15. Group Day Care Homes and Child Care Center as herein defined and regulated in Article VI, Section 10.

C. USES PERMITTED AS SPECIAL EXCEPTIONS

**1. Commercial Mobile Communications Services (CMCS), as regulated by Article VI, Section 26.

D. PROHIBITED USES AND STRUCTURES

All uses and structures not specifically noted. Any additional uses or structures shall not be permitted until this section has been amended as provided in Article VIII.

E. AREA REGULATIONS

The following requirements shall apply to all uses permitted in this district:

1. Front Yard

   All buildings shall be set back from the street right-of-way lines not less than twenty (20) feet.

2. Side Yard

   On the side yard of a lot adjoining a residential district there shall be a side yard of not less than ten (10) feet for one (1) and two (2) story buildings. For buildings exceeding two (2) stories the side yard shall be one (1) foot for each two (2) feet of building height. There shall be a side yard setback from an intersection street of not less than ten (10) feet. In all other cases a side yard will not be required.

3. Rear Yard

   There shall be a rear yard, alley, service court or combination thereof of not less than twenty-five (25) feet.

*Revised: 10/10/89
*Revised: 3/4/99

4. Maximum Lot Coverage

   No building or buildings shall cover more than forty (40%) percent of the lot area.

F. HEIGHT REGULATIONS

   No building shall exceed six (6) stories in height except as provided in Article VI, Section 6.

G. OFF STREET PARKING

   As regulated in Article VI, Section 14.

*H. LANDSCAPING REQUIREMENTS

   As regulated in Article VI, Section 23.

**I. REDELOPMENT AREA DESIGN REVIEW

   All new construction, and any major additions, renovations, restorations, or modifications to the exterior of existing structures, other than normal maintenance, shall be subject to the review and approval of the Planning Commission prior to

any permit being issued. Said proposals to the Planning Commission shall be consistent with the procedures and design specifications set forth in the "East Jackson and Downtown Core Urban Areas Design Guidelines".

END OF ARTICLE V, SECTION 8 B-1.

*Approved:: 12/3/96
**Approved: 8/4/09

SECTION 9
B-2 NEIGHBORHOOD BUSINESS DISTRICT

A. GENERAL DESCRIPTION

This district is established to provide areas in which to meet the needs of the immediate neighborhood. This is a restricted business district, limited to a narrow range of retail service and convenience goods and services. This district is designed for areas where large business operations are undesirable.

B. USES PERMITTED

Property and buildings in a B-2 Neighborhood Business District shall be used only for the following purposes:

1. Food market including specialty foods such as: bakery goods, delicatessen goods and meats.

2. Drug store including: fountain service, book and reading matter, tobacco, vanity goods and pharmacy.

3. Barber shop and beauty shop.

4. Laundry and dry cleaning collection stations; self-service laundry.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

IMPORTANT NOTICE

THE APPRAISER HAS MADE AN ESTIMATE OF VALUE ON THIS PROPERTY TO DETERMINE ITS REASONABLE MARKET, LOAN VALUE OR INSURANCE VALUE. THIS APPRAISAL, HOWEVER, DOES NOT ASSURE THAT THE STRUCTURE WILL BE SATISFACTORY TO YOU IN ALL RESPECTS OR THAT ALL EQUIPMENT WILL OPERATE PROPERLY. A THOROUGH INSPECTION OF THE PROPERTY BY YOU OR A REPUTABLE INSPECTION FIRM MAY HELP MINIMIZE ANY PROBLEMS THAT COULD ARISE. PARTICULAR ATTENTION SHOULD BE GIVEN TO PLUMBING, HEATING, ELECTRICAL AND ROOFING COMPONENTS.

LIMIT OF LIABILITY

LIABILITY OF DAVID W. HORTON AND/OR OTHER APPRAISERS WHO ASSISTED WITH THIS APPRAISAL ARE LIMITED TO THE FEE COLLECTED FOR THE SERVICE RENDERED, AND THEN ONLY TO THE CLIENT. THERE IS NO ACCOUNTABILITY OR LIABILITY TO ANY THIRD PARTY. THE FEE FOR OUR REPORT IS FOR THE SERVICES RENDERED AND NOT FOR THE TIME SPENT ON THE PHYSICAL REPORT.

SUPPLEMENTAL #2
November 12, 2015
11:52 am

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

"NO ENVIRONMENTAL HAZARDS OBSERVED"

ENVIRONMENTAL INSPECTION DISCLAIMER

The Appraiser(s) working on this Project are Not Environmental Experts and do not represent themselves as such. We have or will report observed conditions that the typical layperson might observe, however, experts must be selected by the lender, seller or buyer if they feel such an expert is needed.

The Appraiser(s) is not an expert in the field of hazardous materials:

The Appraisal was prepared for lending or insurance purposes and does not constitute a hazardous material inspection of the property.

The only way to be certain as to the condition of the property with respect to environmental hazards is to have an expert in the field inspect the property and:

The Appraisal should not be relied upon as to whether or not environmental hazards actually exist on the property.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

APPRAISAL TERMINOLOGY

APPRAISAL: An estimate or opinion of value, arrived at and substantiated by a knowledgeable collection and processing of all pertinent data.

APPROACHES TO VALUE: There are three traditional methods of arriving at value: cost of replacement or reproduction, market or comparable sales, and income. Theoretically, the cost approach may set the upper limit or value and the income approach, the lower limit.

ASSESSED VALUE: The value amount assigned to taxable property by an assessor.

BAND OF INVESTMENT: A method of developing a capitalization rate by a weighted average based on financing terms and equity yield requirements.

CAPITALIZATION RATE: A percentage, expressed as a decimal, which provides for yield and for a recapture of capital.

CORRELATION: As a matter of judgment, the appraiser arrives at a value conclusion, a point within the limits of the range indicated by the different approaches to value used in the appraisal process.

COST APPROACH: A summation approach: land value plus depreciated improvement value.

DEPRECIATION: Loss in market value for any reason.

EXTRAORDINARY ASSUMPTION: Extraordinary Assumptions presume as fact otherwise uncertain information about physical, legal, or economic characteristics of the subject property; or about conditions external to the property, such as market conditions or trends; or about the integrity of data used in an analysis. This condition may or may not be applicable with this report.

HYPOTHETICAL CONDITION: Hypothetical Conditions assume conditions contrary to known fact about physical, legal, or economic characteristics of the subject property; or about conditions external to the property, such as market conditions or trends; or about the integrity of data used in an analysis. This Condition may or may not be applicable with this report.

INCOME APPROACH: Valuation of property based on its income-producing capabilities.

INSURANCE VALUE: Value used by insurance companies as the basis for insurance. Often considered to be replacement or reproduction cost plus allowances for debris removal or demolition less deterioration and non-insurable items. Sometimes cash value or market value, but often entirely a cost concept.

INTEREST RATE: A specified rate on a real estate loan.

INVESTMENT RETURN RATE: The rate of earnings on a real estate investment.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

INVESTMENT VALUE: Worth to an individual, considering his objectives, special financial terms, and personal income tax position. It may differ from market value, which is considered to be value to persons in general.

MARKET APPROACH: Valuation of real property by analysis and use of selling price.

MARKET VALUE: Value to persons in general; the most probable selling price.

MORTGAGE OR TRUST DEED: Legal document making property security for the repayment of a loan, terms of which are stipulated in a Promissory Note.

REAL ESTATE: Land and that which is permanently attached thereto by man or nature and would, in normal arm's length transaction, be exchanged with the land without separation or specification and individual evaluation.

REAL PROPERTY: The legally enforceable "Rights of Ownership" in real estate.

REMAINING ECONOMIC LIFE: The estimated number of years in which the property improvements are presumed to show a productive capability.

RENTAL VALUE: (Market Value) The fee per specified period for use of a property as indicated by competition.

VALUE: A definition most applicable to any technique of the income approach: Value is the present worth of future net benefits. Value is not necessarily equal to either cost or price.

VALUE IN USE: The equivalent of Market Value, except it cannot be tested or measured by comparable sales.

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

BRADLEY WYATT DEAN
DAVID HORTON & ASSOCIATES, INC.
P.O. BOX 907
JACKSON, TN 38302

LICENSE

Tennessee Real Estate Appraiser Commission
Tennessee Certified General Appraiser
License #2544

EDUCATION

Jackson Central Merry High School
1992 – 1996

Jackson State Community College
Fall 1996, Fall 1997

APPRAISAL COURSES:

Foundations of Real Estate Appraisal – Knoxville, Tennessee
Standards of Professional Practice – Nashville, Tennessee
Appraising the Single Family Residence – Jackson, Tennessee
Basic Residential HUD Appraisal Requirements – Memphis, Tennessee
Real Estate Appraisal Methods – Jackson, Tennessee
ANSI Standards – Jackson, Tennessee
Financial Analysis of Income Properties – St. Louis, Missouri
Introduction to Income Property Appraising – St. Louis, Missouri
Techniques of Income Property Appraising – St. Louis, Missouri
Standards of Professional Practice, 2003 Edition – Nashville, Tennessee
5.0 National USPAP Update Course – Jackson, TN
Basic Accrued Depreciation – Nashville, TN
Information Technology and the Appraiser – Mckissock Online Course
Made in America, Appraising Factory Built Housing – Mckissock Online Course
National USPAP Update Course – Memphis, TN
FHA, the URAR, & the 1025 – Memphis, TN
Disclosures & Disclaimers – McKissock Online Course
The Cost Approach – McKissock Online Course
Practice of Condemnation Appraisal – Nashville, TN
National USPAP Update Course – Jackson, TN

SUPPLEMENTAL #2
November 12, 2015
11:52 am

West Tennessee Healthcare
Re: 616 West Forest Avenue
Jackson, TN 38301

BRADLEY WYATT DEAN
DAVID HORTON & ASSOCIATES, INC.
P.O. BOX 907
JACKSON, TN 38302

PARTIAL CLIENT LIST

Madison County, TN
City of Jackson, TN
Gibson County, TN
Hardin County, TN
City of Savannah, TN
Chester County, TN
Jackson Energy Authority
State of Tennessee
United States Department of Agriculture
Tennessee Valley Authority
West Tennessee Healthcare, Inc.
West Tennessee Healthcare Foundation
West Tennessee ENT Clinic, P.A.
Mid-South Heart Center
West Tennessee Bone & Joint
Jackson Surgical Associates
Semmes-Murphy Clinic
McNairy Regional Hospital
Oral Surgery of West Tennessee
Williams & Williams Chiropractic Clinic
Madison-Haywood Developmental Services
BancorpSouth
Commercial Bank & Trust
Bank of Madison County
Bank of Jackson
First South Bank
First State Bank
First Bank
First Horizon National Corp.
Peoples Bank
SunTrust Bank
First Community Bank
Carroll Bank & Trust
Bank of Crockett
Community South Bank
AmSouth Bank
Postal Employee Credit Union
Business Loan Center, LLC
Community Bank
Perkins Corporation
TLM Associates

9663087

26547

State of Tennessee

TENNESSEE REAL ESTATE APPRAISER COMMISSION

CERTIFIED GENERAL REAL ESTATE APPRAISER

BRADLEY WYATT DEAN

This is to certify that all requirements of the State of Tennessee have been met.

ID NUMBER: 00002544
LIC STATUS: ACTIVE
EXPIRATION DATE: 05/31/2017

IN-1313
DEPARTMENT OF
COMMERCE AND INSURANCE

November 12, 2015
11:52 am

SUPPLEMENTAL #2

CERT001

74

SUPPLEMENTAL #2
November 12, 2015
11:52 am

Exhibit 5

HealthSpring

Humana Choice Care

Humana Military Healthcare Services (TriCare)

Humana Medicare Advantage

Williams Steel

Work Partners

Underwriters Service Corporation

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response: The project will have a positive effect on the health care system by providing a new state-of-the-art care setting designed to permit efficiencies in the delivery of patient care and lower overall health care costs to the system. West Tennessee Rehabilitation Center is the only existing provider in its primary service area and does not seek approval for new additional health care services. The other facility in the service area, HealthSouth Cane Creek, is part of the contemplated joint venture, and as such, there will be no negative impact on other existing providers.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Response: The following table presents the projected staffing at West Tennessee Rehabilitation Center after implementation of this project.

SUPPLEMENTAL #2

November 12, 2015

11:52 am

Position	FTE	Salary Range	Tennessee Entry	Tennessee Median	Tennessee Experienced
Administrator	1.0	$54.90-$93.33			
Director of Nursing	1.0	$41.53-$70.60			
Controller	1.0	$31.96-$54.02	$ 19.51	$ 26.35	$ 35.34
Marketing	1.5	$31.96-$54.02	$ 19.31	$ 23.12	$ 47.52
Director of Therapy	1.0	$41.53-$70.60			
Director of Quality	1.0	$28.06-$47.14	$ 30.28	$ 46.76	$ 66.16
Rehab Liaison	3.0	$24.64-$41.15			
Admission Supervisor	3.0	$18.79-$31.32	$ 9.84	$ 13.40	$ 16.20
Other Administration	4.0	$14.62-$24.37			
Health Information Man	2.0	$28.06-$47.14	$ 16.78	$ 35.70	$ 43.35
Receptionist	2.0	$10.71-$17.85	$ 9.39	$ 11.48	$ 13.02
Nurse Manager	4.0	$28.06-$47.14			
Registered Nurse	26.0	$21.53-$35.88	$ 20.37	$ 23.83	$ 27.10
Licensed Practical Nurse	8.0	$16.60-$27.67	$ 12.71	$ 16.09	$ 17.95
Nurse Aide	16.0	$9.63-$16.05	$ 8.74	$ 16.22	$ 17.47
Unit Clerk/Secretary	2.0	$10.71-$17.85	$ 9.39	$ 12.52	$ 16.06
Physical Therapist	6.0	$28.06-$47.14	$ 31.15	$ 37.61	$ 43.68
Speech Therapist	3.0	$24.64-$41.15	$ 19.16	$ 29.35	$ 36.25
Occupational Therapist	5.0	$28.06-$47.14	$ 31.46	$ 37.01	$ 14.63
Therapy Aides	3.0	$10.71-$17.85	$ 14.30	$ 10.75	$ 11.15
Therapy Assistants	7.0	$18.79-$31.32	$ 9.32	$ 11.97	$ 13.85
Case Managers	3.0	$21.53-$35.88	$ 14.86	$ 21.31	$ 25.38
Pharmacist	1.5	$41.53-$70.60	$ 37.81	$ 58.13	$ 60.85
Pharmacy Tech	1.0	$10.71-$17.85	$ 10.00	$ 12.38	$ 14.56
Respiratory Therapist	1.5	$21.53-$35.88	$ 16.63	$ 19.17	$ 21.99
Central Supply Clerk	1.5	$10.71-$17.85	$ 8.13	$ 9.88	$ 12.15
	109.0				

Position	FTE	Salary Range	Tennessee Entry	Tennessee Median	Tennessee Experienced
Supervisor Dietary	1.0	$21.53-$35.88			
Cook	2.0	$10.71-$17.85	$ 11.49	$ 13.85	$ 16.78
Dietary Aide	4.0	$8.15-$13.59	$ 8.08	$ 10.22	$ 13.11
Dietician	1.0	$18.79-$31.32	$ 13.48	$ 19.63	$ 26.06
Supervisor Housekeeping	1.0	$18.79-$31.32	$ 10.32	$ 11.74	$ 16.92
Housekeepers	5.0	$8.15-$13.59	$ 8.10	$ 9.15	$ 11.17
Maintenance Supervisor	1.0	$31.96-$54.02	$ 19.07	$ 27.12	$ 32.73
Maintenance Assistance	1.0	$12.99-$21.65	$ 11.04	$ 18.53	$ 21.53
	16.0				
TOTAL	125.0				

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response: Jackson-Madison County General Hospital currently employs a professional staff for the West Tennessee Rehabilitation Center. The applicant anticipates being able to recruit additional staff without difficulty, if necessary. On-going staff recruitment and training is accomplished as needed through:

- Corporate recruitment programs (as implemented through its extensive network at national and regional levels) which aid in locating qualified administrative, clinical, and nursing leadership;
- National training programs and local in-services about new programs;
- Student scholarship programs;
- Newspaper and journal advertisements (local, state-wide, and national);
- Internet advertising;

Supplemental #2 Additonal Clarification

-Original-

West Tn Rehabilitation Center

CN1510-044

West Tennessee Healthcare

620 Skyline Drive • Jackson, Tennessee 38301 • 731-541-5000 • www.wth.org

SUPPLEMENT

November 17, 2015

Mr. Jeff Grimm
HSD Examiner
Tennessee Health Service and Development Agency
502 Deaderick Street, 9th Floor
Nashville, Tennessee 37243

RE: Certificate of Need Application CN1510-044
West Tennessee Rehabilitation Center – Establishment of a 48 Bed Freestanding Rehabilitation Hospital-Responses

Dear Mr. Grimm:

Per your correspondence of November 16, 2015, enclosed please find in triplicate replacement page 37-R with revised amounts for Item 5 (average gross charge and average net patient revenue).

Feel free to contact me with additional questions. I may be reached at vicki.lake@wth.org or (731) 984-2160.

Sincerely,

Victoria S. Lake
Director, Market Research and Community Development

Enclosure

SUPPLEMENTAL

NOV 18 '15 PM 12:02

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Madison

NAME OF FACILITY: West Tennessee Rehabilitation Center

I, VICTORIA S. LAKE, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title
Director, Market Research & Community Dev.

Sworn to and subscribed before me, a Notary Public, this the 17 day of November 2015, witness my hand at office in the County of Madison, State of Tennessee.

NOTARY PUBLIC

My commission expires 9-21, 2016.

RANDALL L HAMPTON
STATE OF TENNESSEE NOTARY PUBLIC
MADISON COUNTY TN

HF-0043

Revised 7/02

ADDITIONAL CLARIFICATION – SUPPLEMENTAL

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response: The following table provides the estimated average gross charge, average deduction from operating revenue, and the average net charge for the first calendar year after implementation of the proposed project.

	FY2018
Average Gross Charge	$1,814/day
Average Deduction	$628/day
Average Net Patient Revenue	$1,186/day

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: For FY2015, the average charge per day for patient care was $1,735. The projected charge for FY2018, the first year after implementation of the project, is $1,814 per patient day.

6. B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: West Tennessee Rehabilitation Center and HealthSouth Cane Creek are the only providers of inpatient rehabilitation services in the service area of West Tennessee Healthcare. For 2013, the average charge per patient day for HealthSouth Cane Creek was $1,323.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response: The projected utilization rates are incremental to current operations, and the project will result in a small increase in patient charges.